

66 10001

BALTIMORE CITY HEALTH DEPARTMENT

66 10001

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Edward Grimsley

2. DATE AND HOUR PRONOUNCED DEAD

10/4/66 7:00 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Arkansas

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Menila

D. STREET ADDRESS (If rural, give location)

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Feb. 29, 1909

9. AGE (In years  
last birthday)

57-56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Grimsley

14. MOTHER'S MAIDEN NAME

Viennie Overman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

E. L. Wood, 10713 Rosehaven, Fairfax, Va.

18. CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/4/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-8-66

23C. NAME OF CEMETERY or CREMATORY

McGrew Cemetery

23D. LOCATION

(City, town, or county)

Senath, Missouri

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 5 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Ulrich Funeral Home, P.O. Box 1000, Baltimore, Md.

ADDRESS





FUNERAL DIRECTOR: IMPORTANT

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a funeral home. If death occurred elsewhere, it must be completed by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 10002	
CERTIFICATE OF DEATH				Registered No. 66 10002	
BIRTH NO. 66 10002		1. NAME OF DECEASED <b>Jones, William E.</b>		2. DATE AND HOUR OF DEATH <b>10/2/66 6:55 P</b>	
M.E. CASE NO.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
1. NAME OF DECEASED (Type or Print)		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
5. SEX <b>MALE</b>		6. RACE <b>NEGROID</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	
8. DATE OF BIRTH <b>2-4-00</b>		9. AGE (In years lost birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>HENRY FOX JONES</b>	
14. MOTHER'S MAIDEN NAME <b>CHARITY WILSON</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-8828</b>	
17. INFORMANT <b>Mrs Agnes McDaniels</b>		ADDRESS <b>643 Bartlett Ave</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Acquired Afibrinogenemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>about 9 hr.</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Intravascular clotting</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Sepsis or Cancer</b>		20. MEDICAL CERTIFICATION		21. MEDICAL CERTIFICATION	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>II</u> (this hospital) attended the deceased from <b>9am 10/2/ 1966</b> to <b>6:55 pm 10/2 19 66</b> , that <u>I</u> (we) last saw the deceased alive on <b>10/2 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C.H. Brown, III</b>				23B. DATE SIGNED <b>10/2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>C.H. Brown, III</b>				23D. ADDRESS <b>The Johns Hopkins Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/6/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, JR</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>			

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66 10003

BALTIMORE CITY HEALTH DEPARTMENT

66 10003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

HAMP STOVER

2. DATE AND HOUR PRONOUNCED DEAD

Oct 1st 66 12:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1631 Pennsylvania Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 14-02

D. STREET ADDRESS (If rural, give location)

1631 Pennsylvania Ave

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

5/22/95

9. AGE (In years last birthday)

71

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during last working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF

USA

13. FATHER'S NAME

Isham Stover

14. MOTHER'S MAIDEN NAME

Molly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs Marjorie Johnston

ADDRESS

1637 Gwynns Falls

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) DUE TO Arteriosclerotic and  
Hypertensive Cardio  
Vascular Disease.

(B)

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Werner U. Spitz, M. D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct 1st 66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10/5/66

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

Baltimore Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 5 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead

ADDRESS

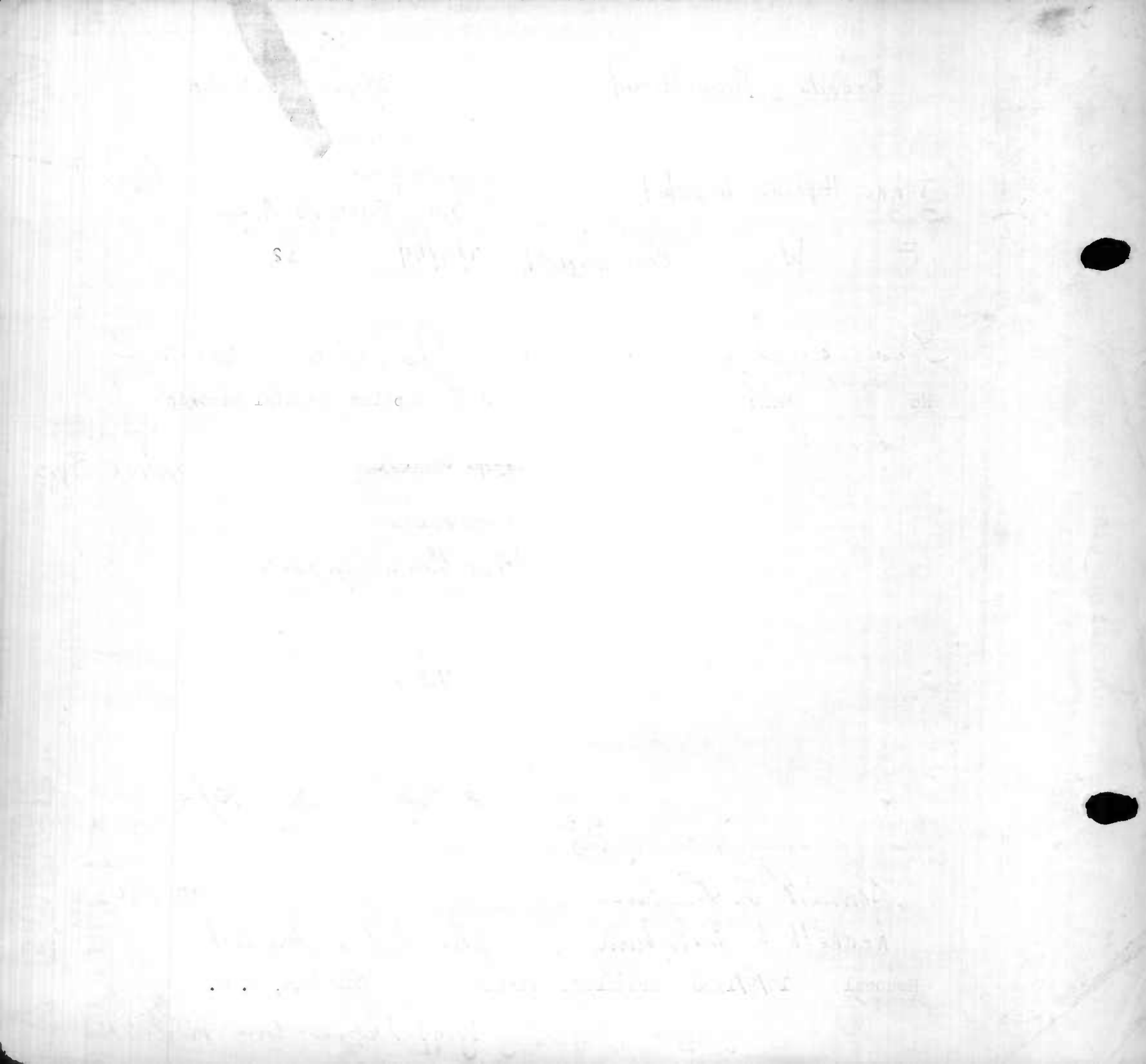
1206 W North Ave



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10004				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 10004	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Brenda Broadhead</i>		2. DATE AND HOUR OF DEATH <i>10/3/66 2:30 AM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>South Carolina</i>		B. COUNTY <i>Columbia</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>1-37</i>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i>		8. DATE OF BIRTH <i>9/9/44</i>		9. AGE (In years lost birthday) <i>22</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Francis Broadhead</i>				14. MOTHER'S MAIDEN NAME <i>Janie Mattoy</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Johns Hopkins Hospital Records</i>				ADDRESS	
18. <i>744.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Myasthenia</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>Pneumonia</i> <i>Myasthenia gravis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>approx 3 yrs</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i>									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>June 1963</i> to <i>10/3</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/3</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.									
23A. SIGNATURE <i>Kenneth L. Brigham</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10.3.66</i>			
23C. PHYSICIAN'S NAME (Type) <i>Kenneth L. Brigham</i>				23D. ADDRESS <i>Johns Hopkins Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>10/5/1966</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Columbia, S. C.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. J. ...</i>		ADDRESS <i>Balto., Md. North LPA Ave</i>			



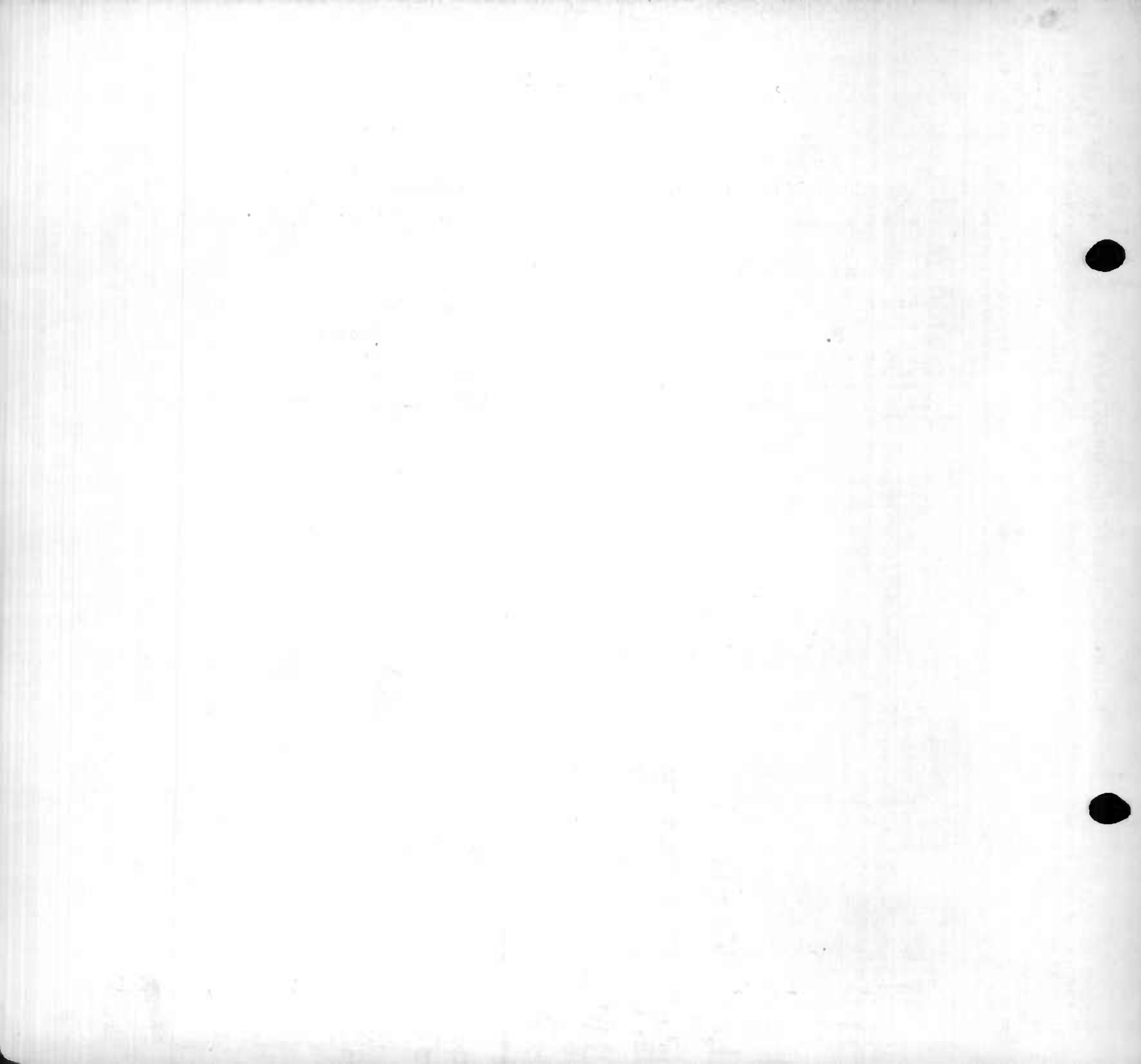


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 10005		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10005	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>M.E. CASE NO.</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>STEARNS, ELIZABETH Lewis</b>			2. DATE AND HOUR OF DEATH <b>10/4/66 4:40 PM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>VIRGINIA</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>FREDERICKSBURG</b> D. STREET ADDRESS (If rural, give location) <b>720 WILLIAMS ST.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>9-3-1901</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>			11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>P. FRANK STEARNS</b>			14. MOTHER'S MAIDEN NAME <b>Thomas BETTIE LEWIS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Miss Emeline Stearns same address</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>137X I CARCINOMATOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CA of PANCREAS</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> 19 <b>66</b> to <b>10/4</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Pete J. Rosen</b>				23B. DATE SIGNED <b>10/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. PETE ROSEN</b>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10/4/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>City Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Fredericksburg, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Tackner &amp; Sons Baltimore, Md.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10006				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10006	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BACH, FRANK A.</b>				2. DATE AND HOUR OF DEATH <b>Oct. 2, 1966 12 50 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>12-01</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>12 WENDOVER ROAD</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>01-11-82</b>	9. AGE (in years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EXECUTIVE - retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-1399</b>		17. INFORMANT ADDRESS <b>Union Memorial Hospital Records</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> (A) DUE TO  (B) DUE TO  (C) DUE TO  INTERVAL BETWEEN ONSET AND DEATH							
18. <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 2 1966</b> to <b>Oct 2 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct 2 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Zoltan, Zarday</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Ticken</b>		ADDRESS <b>Baltimore, Md.</b>	

- I -

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10007				BALTIMORE CITY HEALTH DEPARTMENT				66 10007			
CERTIFICATE OF DEATH								Registered No. _____			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>MABEL I. VOLK</b>				2. DATE AND HOUR OF DEATH <b>10-2-66 2:35 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b>							
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b> (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>							
				D. STREET ADDRESS (If rural, give location) <b>118 E. Belvedere Ave. 12</b>							
5. SEX <b>F</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>April 9, 1895</b>		9. AGE (In years last birthday) <b>71</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTH PLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George W. Mansdorfer</b>				14. MOTHER'S MAIDEN NAME <b>Delila Cremer</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. W. Milton Volk</b>				ADDRESS <b>same address as above</b>	
18. <b>4201 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Shock.</b>				CAUSE OF DEATH (A) DUE TO <b>Acute Myocardial Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease.</b>				(B) DUE TO <b>Arteriosclerotic heart disease.</b>				<b>3 days.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>10-1-66</b> to <b>10-2-66</b> , that (I) (we) last saw the deceased alive on <b>10-2-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>B. Venkatachalam</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>10-2-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>B. VENKATACHALAM.</b>				23D. ADDRESS <b>Mercy Hospital, Balt, Md.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Tinkler &amp; Sons</b>		ADDRESS <b>Baltimore, Md.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 10008		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10008	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>M.E. CASE NO.</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>POLLHEIM, HERMAN</b>			2. DATE AND HOUR OF DEATH <b>Oct. 1, 1966, 6 17 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION: <b>44 Union Memorial Hosp.</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: <b>MARYLAND</b> B. COUNTY: <b>12-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township): <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location): <b>3900 GREEN MOUNT AVE</b>		
5. SEX: <b>M</b>	6. RACE: <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>01-03-86</b>	9. AGE (In years last birthday): <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Asst. Buyer - Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Hecht Company</b>	11. BIRTHPLACE (State or foreign country): <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?: <b>U.S.</b>
13. FATHER'S NAME: <b>WILLIAM POLLHEIN</b>			14. MOTHER'S MAIDEN NAME: <b>MARY FENNER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): <b>No None</b>		16. SOCIAL SECURITY NO.: <b>212-09-9306</b>	17. INFORMANT ADDRESS: <b>Mr. Herman F. Pollheim 1303 E. 36th St. #18</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>609X I</b> <b>E. COLI SEPTICAEMIA</b> <b>URINARY TRACT INFECTION</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: <b>CEREBROVASCULAR THROMBOSIS</b>		
19A. DATE OF OPERATION: <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:	20A. AUTOPSY? (Yes or No): <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):	
21D. TIME OF INJURY (APPROX.): (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED: While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?:	
22. I certify that (I) (this hospital) attended the deceased from <b>9/10/66</b> 19 to <b>10/1</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>10/1</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE:			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED: <b>10/1/66</b>
23C. PHYSICIAN'S NAME (Type): <b>ZOLTAN ZARDAY</b>			23D. ADDRESS: <b>THE UNION MEMORIAL HOSPITAL, Union Memorial Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify): <b>Burial</b>	24B. DATE: <b>Oct. 4, 66</b>	24C. NAME OF CEMETERY or CREMATORY: <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State): <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.: <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR: <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR: <b>Wm. F. Tichner &amp; Sons</b>	

2000 GREEN MOUNTAIN

NO. 10

MASSACHUSETTS

MARY FEMMER

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BIRTH NO. 66 10009		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10009	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Victoria Gray			2. DATE AND HOUR OF DEATH 10-2-66 12:15 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-12 D. STREET ADDRESS (If rural, give location) 4940 EASTERN AVENUE 21224		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 8-12-79	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Washington District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME Victoria Hughes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT RECORDS-BCH-4940 Eastern Avenue		
18. 722.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO Rheumatoid arthritis (C)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 6 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CVA		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 9/10 1962 to 10/2 1966, that (H) (we) last saw the deceased alive on 10/2 1966 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Phillip L. Hall M.D.				23B. DATE SIGNED 10/2/66	
23C. PHYSICIAN'S NAME (Type) PHILLIP L. HALL M.D.			23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. BALTIMORE CITY HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 6 1966		24C. NAME of CEMETERY or CREMATORY Park	
24D. LOCATION Baltimore		24E. NAME of REGISTRAR Robt E. Farley, MA		24F. FUNERAL DIRECTOR U. Brooks Ruggold	
24G. DATE REC'D BY HEALTH DEPT. OCT 5 1966		24H. NAME of REGISTRAR Robt E. Farley, MA		24I. ADDRESS 14637 N. Cany St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10010</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="float: right;">66 10010</span>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>DAVIS, JOHN G. SR.</b>		2. DATE AND HOUR OF DEATH <b>OCT. 4, 1966. 8:05 AM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>Baltimore</b>	
(If not in hospital or institution, give street address or location) <b>33RD AND CALVERT ST., BALTIMORE, MD</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>REISTERTOWN</b>		D. STREET ADDRESS (If rural, give location) <b>123 NORTHWAY ROAD</b>	
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>02/21/06</b>	9. AGE (In years last birthday) <b>60</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE CORSPD.</b>
10B. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse Elec. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GOMER T. DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>Ellen G. Williams</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>189-05-5231</b>		17. INFORMANT ADDRESS <b>Mrs. Elsie Davis, (Same)</b>	
18. <b>434.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HEMORRHAGIC CONGESTION OF LUNGS</b> <b>ATLANTA, MD.</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 25, 1966</b> to <b>OCT. 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT. 4, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Pmcl</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/4/66.</b>	
23C. PHYSICIAN'S NAME (Type) <b>William H. Renner</b>		23D. ADDRESS <b>The Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/66.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>	

3300 AND CALVERT ST., BALTIMORE, MD. 123 HIGHWAY ROAD  
REGISTERED

M. WHITE WARED 02/21/00 00

PAID TO (NAME) PENNSYLVANIA

JOHN T. DAVIS

Oct. 11 1902 00 00

WILLIAM F. ROBERT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10011		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10011	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Charles J. Dieter</i>			2. DATE AND HOUR OF DEATH <i>Oct. 2, 1966 7:30 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2820 Kentucky Ave.</i>			A. STATE <i>Md.</i> B. COUNTY <i>27-01</i>		
5. SEX <i>male</i> 6. RACE <i>white</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>			8. DATE OF BIRTH <i>10-9-1893</i> 9. AGE (in years last birthday) <i>72</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Maintenance Dept. Dairy</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Jacob Dieter</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Manners</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			17. INFORMANT <i>Margaret M. Dieter</i> ADDRESS <i>same</i>		
16. SOCIAL SECURITY NO. <i>245075948</i>			18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Myocardial Disease</i> <i>Arteriosclerotic Cardiovascular Disease</i> <i>Emphysema</i>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <i>16 yrs.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			20. DATE OF OPERATION <i>0</i> 21. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>1-7-50</i> to <i>3-11-66</i> , that (I) (we) last saw the deceased alive on <i>3-11-1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Emulton C. Rang</i>			23B. DATE SIGNED <i>10-3-66</i>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS <i>2117 Belair Rd Balto 21213</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>			24B. DATE <i>10-5-66</i>		
24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc</i>			25D. ADDRESS <i>Baltimore, Md.</i>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10012				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10012	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HOWARD A. ROUTSON</b>				2. DATE AND HOUR OF DEATH <b>Oct. 4, 1966. 7:35 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2602</b>			
5. SEX <b>Male</b>				6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	
8. DATE OF BIRTH <b>April 25, 1908.</b>		9. AGE (In years last birthday) <b>58</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Electrical</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Harry Routson</b>			
14. MOTHER'S MAIDEN NAME <b>Pearl Taylor</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-07-4907</b>				17. INFORMANT <b>Mrs. Marie C. Routson</b>			
18. ADDRESS <b>(Same)</b>				19. CAUSE OF DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>D.O.A.</b>			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardio-Vascular Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>			
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 1958</b> to <b>Oct. 4, 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept. 24, 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>do not</del> ) view the body after death.							
23A. SIGNATURE <b>Michael J. Dausch</b>				23B. DATE SIGNED <b>Oct. 4, 1966</b>		23C. PHYSICIAN'S NAME (Type) <b>Michael J. Dausch</b>	
23D. ADDRESS <b>4636 Belair Road</b>				24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>10/7/66.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		25D. ADDRESS <b>21214</b>	



Chas. J. Johnson  
21 - 10 - 1911  
Chas. J. Johnson

Wm. J. Brown

11 - 10 - 1911

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10013		BALTIMORE CITY AND COUNTY		Registered No. 66 10013	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>LAMBERT, FREDERICK WILLIAM</b>			2. DATE AND HOUR OF DEATH <b>OCTOBER 4, 1966 5:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Lutherville</b> D. STREET ADDRESS (If rural, give location) <b>5 BELFAST ROAD</b>		
5. SEX <b>M</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-8-'10</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>employed</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Arrow Seal Co.</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>WILLIAM LAMBERT</b>		
14. MOTHER'S MAIDEN NAME <b>ALBERTA HILL</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>216012171</b>			17. INFORMANT <b>CARL LAMBERT, BROTHER</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b>			ADDRESS <b>7 DENISON ST. TIMONIUM</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>5 HOURS</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>			21. SIGNATURE <b>Dr. Kim</b>		
21A. DATE OF OPERATION <b>2</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 4 19 66</b> to <b>OCTOBER 4 19 66</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 4 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Samuel C. Gresham</b>				23B. DATE SIGNED <b>OCTOBER 4, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL C. GRESHAM, M.D.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10-7-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem. Park</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc Baltimore, Md.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

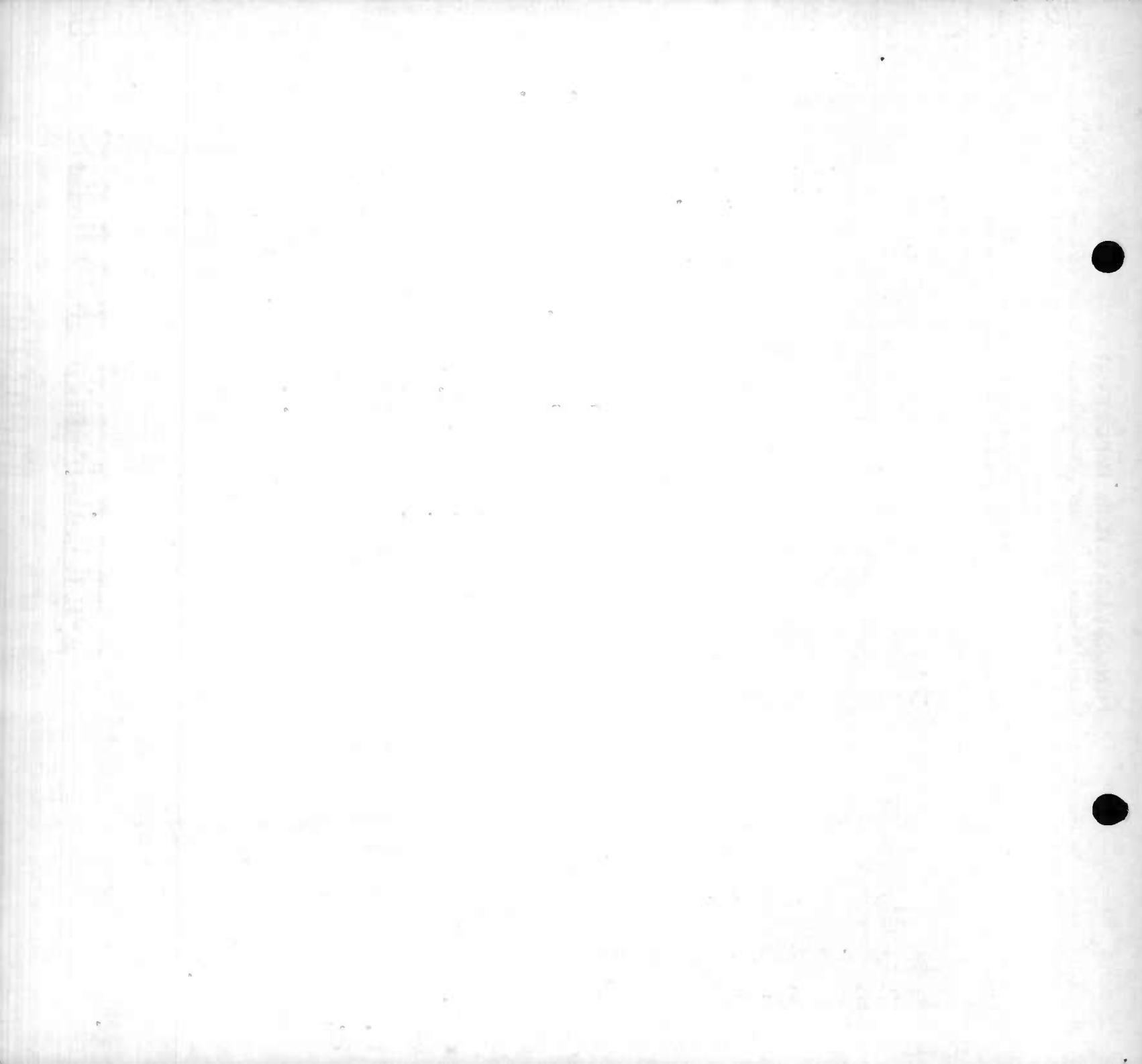
BIRTH NO. <span style="font-size: 1.5em;">66 10014</span>				Baltimore City Health Department		Registered No. <span style="font-size: 1.5em;">66 10014</span>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">John Tyler</div>				2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">10-4-66 1:15 A.M.</div>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center; font-size: 1.2em;">Provident Hospital 1415 Division Street Baltimore, Maryland 21217</div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">15-02</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1316 Bruce Street</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Single</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6-22-14</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">52 yrs.</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Unemployed</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Gochland Virginia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Monroe Tyler</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary G. Tyler</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">yes WWII</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">711-10-1876</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Helen Blackwell (Sister) 3306 Clifton Ave</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Generalized peritonitis</span>				INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3-5 days</span>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Ruptured peptic ulcer of Stomach</span>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">yes</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">October 2, 19 66</span> to <span style="font-size: 1.2em;">October 4, 19 66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">October 4, 19 66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Rosario D. Bello</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">10-4-66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Rosario Bello,</span>				23D. ADDRESS <span style="font-size: 1.2em;">1514 Division Street St. Balto., Md.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10-8-66</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Goochland Co. Cem.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Goochland Va.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 5 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Faby...</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Myrtle E. Pyatt F.H.</span>		ADDRESS <span style="font-size: 1.2em;">1701 Laurens St.</span>	

James H. Bell

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10015		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10015	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) JOHN E. CROUT, Sr.		
2. DATE AND HOUR OF DEATH 10-3-66 7:25 A M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 3711-CROYDON Rd.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/23/96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Good Humor Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Croust		14. MOTHER'S MAIDEN NAME Agnes Ettinger		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-2633		17. INFORMANT Mrs. Rosabell W. Croust ADDRESS 3711 Croydon Rd.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) Pulmonary emphysema DUE TO A.S.C.V.D.		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2-1966 to 10-3-1966, that (I) (we) last saw the deceased alive on 10-3-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Gordon M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-3-66	
23C. PHYSICIAN'S NAME (Type) S. Gordon		23D. ADDRESS Sinai Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-6-66		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
24D. LOCATION (City, town, or county) Baltimore, Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Witzke F.D. ADDRESS 4101 Edmondson Av.	





# FUNERAL DIRECTOR: IMPORTANT

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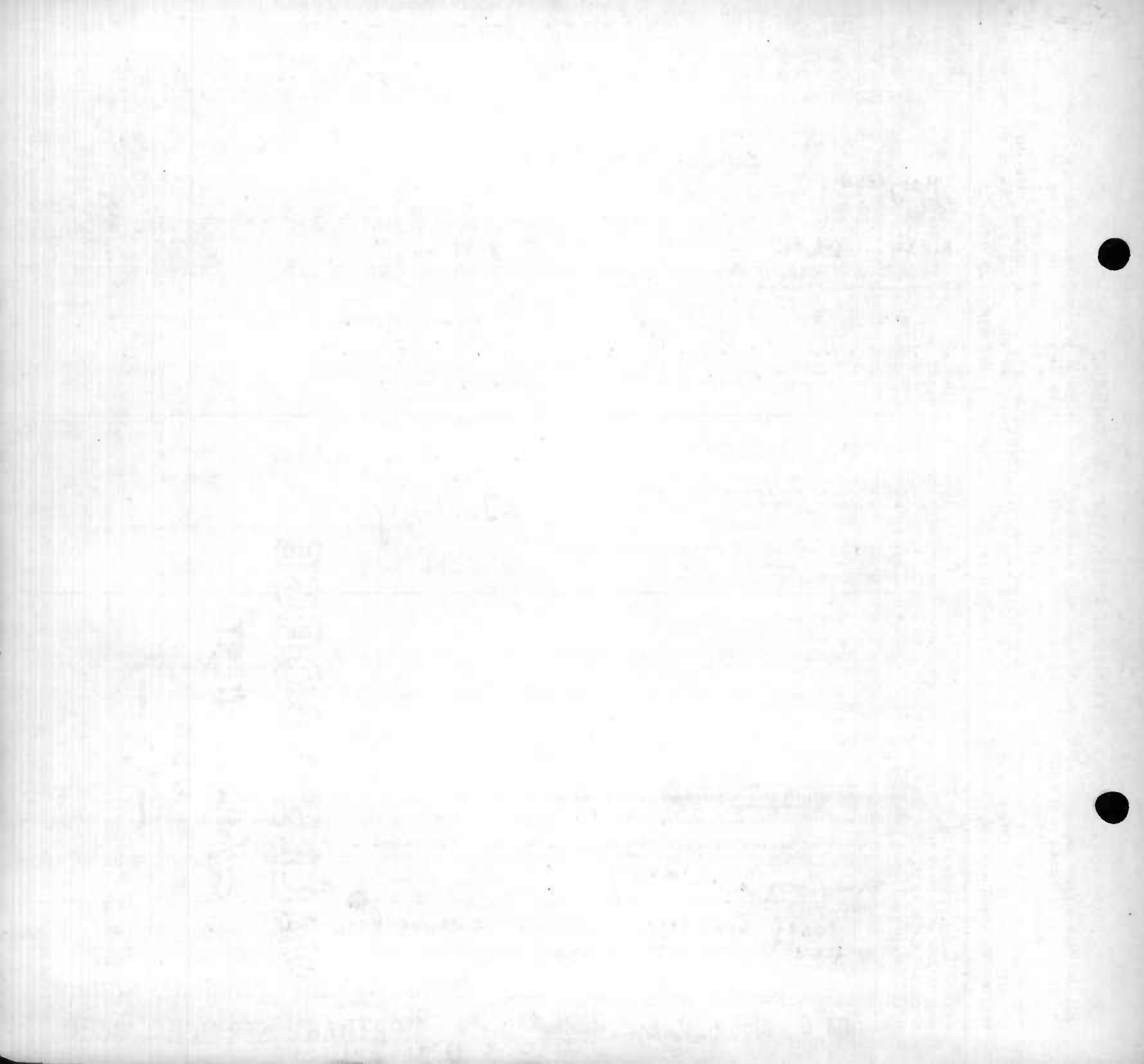
BIRTH NO. <b>66 10016</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 10016</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Avice E. Kent</b>		2. DATE AND HOUR OF DEATH <b>Oct. 2, 1966</b> <b>11 58 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4508 Dunland Rd. Balto., 29, Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>28-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4508 Dunland Rd.</b>			
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 5, 1979</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ballbearing Fac.</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Late-Henry Williams</b>		14. MOTHER'S MAIDEN NAME <b>Late-Mary Locke</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>049-20-0140</b>	17. INFORMANT <b>Mrs. Avice Howell</b>		ADDRESS <b>4508 Dunland Rd. - Apt. A</b>
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anteriosclerotic heart disease</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/27</b> <b>1966</b> to <b>10/2</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>10/2</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert A. Reiter</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <b>10/3/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Robert A. Reiter</b>		23D. ADDRESS <b>606 Edmondson Ave. 21228</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>10-4-66</b>	24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	25C. FUNERAL DIRECTOR <b>Witzke F.D.</b>		ADDRESS <b>-4101 Edmondson Av.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10017</b>
BIRTH NO. <b>66 10017</b>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Baby Boy PAGE</b>		2. DATE AND HOUR OF DEATH <b>8. 17. 66</b> <b>4<sup>10</sup> P.M.</b>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b>		A. STATE <b>md</b> B. COUNTY <b>Balto</b>		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE # 21221</b>		
<b>46</b>		D. STREET ADDRESS (If rural, give location) <b>327 St Georges Rd 53-00</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>8. 17. 66</b>	9. AGE (In years last birthday) <b>8</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <b>Bernard Andrew Page</b>		14. MOTHER'S MAIDEN NAME <b>Judy Carol Mitcham</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <b>773.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory distress</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <b>Respiratory distress</b> (B) DUE TO <b>Fracture</b> (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>8. 17. 19 66</b> to <b>8. 17. 19 66</b> , that (I) (we) last saw the deceased alive on <b>8. 17. 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Josef Grumberg</b>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>Josef Grumberg</b>		23D. ADDRESS <b>Lutheran Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9/29/66</b>		24C. NAME of CEMETERY or CREMATORY
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10018 4</u>	
BIRTH NO. <u>66 10018</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>66-18725</u>					
1. NAME OF DECEASED (Type or Print) <u>Baby Girl BELL</u>		2. DATE AND HOUR OF DEATH <u>9/3/66</u> <u>11:00</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN Hospital</u>		A. STATE <u>Penna.</u> B. COUNTY <u>Norristown</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>V-35</u>			
		D. STREET ADDRESS (If rural, give location) <u>39 E Jacoby Street</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>9-3-66</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Ooys: Hours: Min. <u>10</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Charles E BELL</u>			
14. MOTHER'S MAIDEN NAME <u>Phyllis J. Washington</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Phyllis BELL (mother)</u>			
18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>9/3/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12:10 PM 9/3/66</u> to <u>12:30 PM 9/3/66</u> , that (I) (we) lost saw the deceased alive on <u>9/3/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>SK</u>		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9/3/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. KIM</u>		23D. ADDRESS <u>Lutheran Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/29/66</u>		24C. NAME of CEMETERY or CREMATORY <u>ANATOMY HOSPITAL</u>	
24D. LOCATION (City, town or county)		(State)			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, MD</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
25D. ADDRESS		25E. MORTUARY SERVICE - <u>BCHD</u>			

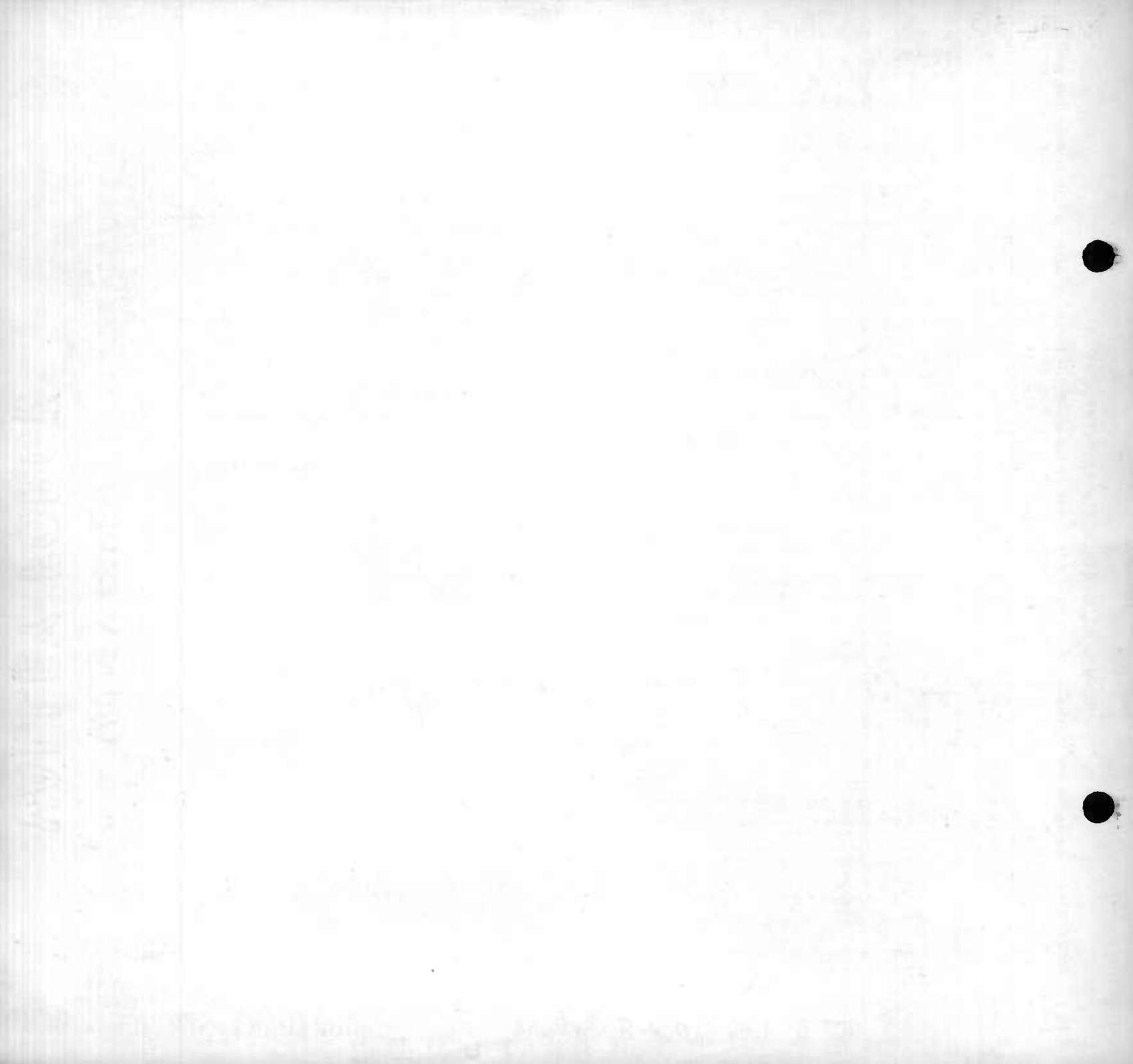


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 10019					Registered No. 66 10019				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
YOST MR. RANDOLPH					9/14/66 9:15 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
Church Home + Hospital 35					Md. BALTIMORE 2-03 726 S. Broadway				
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH 7/20/13		9. AGE (In years lost birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph T. Yost					14. MOTHER'S MAIDEN NAME Mary Prince				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Arizona Michael Frederick Rd. Furkstown Md.		
18. 199.21					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) METASTATIC CARCINOMA MONTHS. DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) Metastasis to brain DUE TO				
(C)					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 8/10/66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Infiltrate			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/1/66 to 9/14/66, that (X) (we) last saw the deceased alive on 9/14/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Francisco Baltazar Jr.							23B. DATE SIGNED 9/14/66		23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS M.D.							23E. FURNAL DIRECTOR		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 9/20/66			24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FURNAL DIRECTOR			

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD





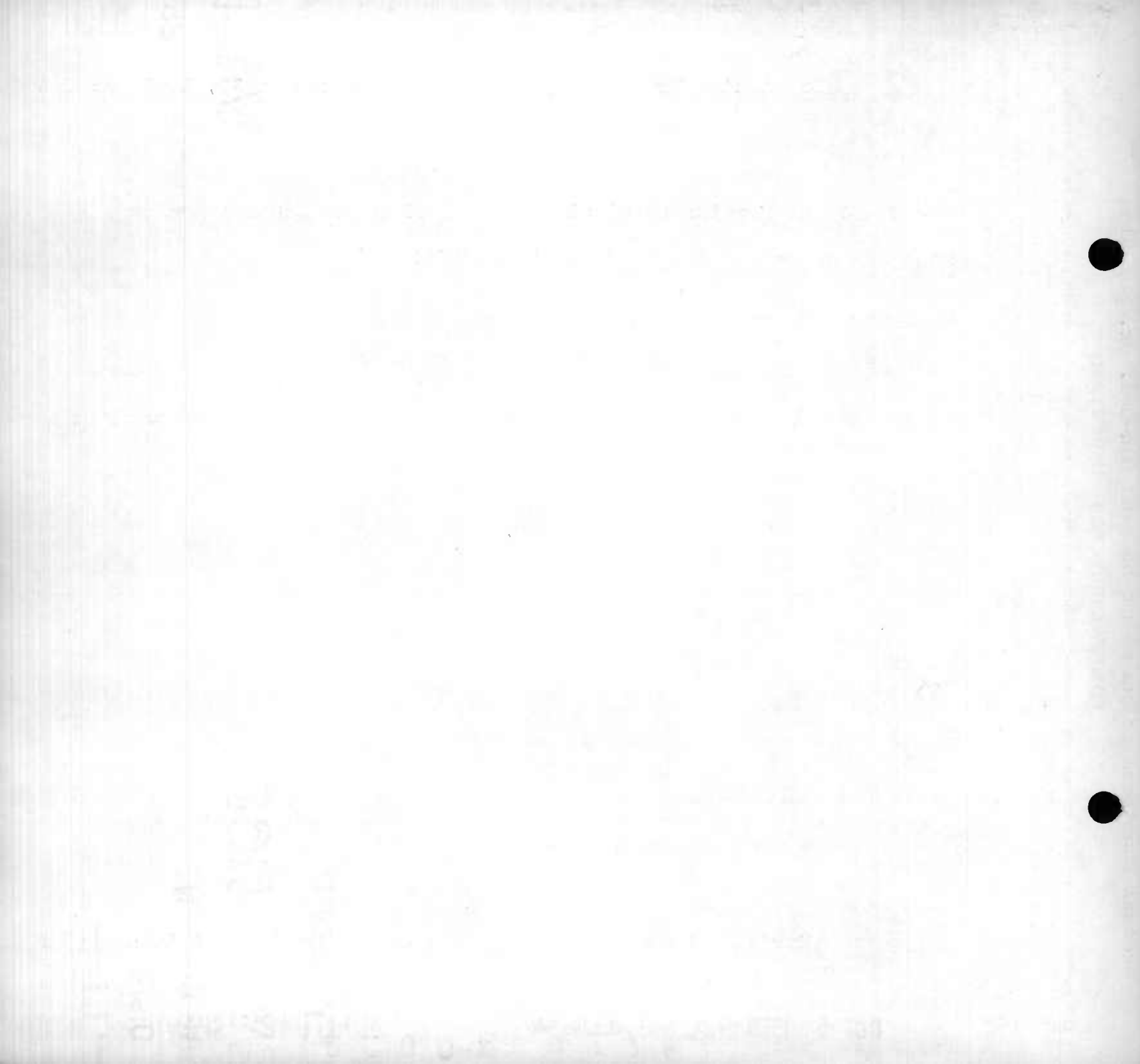


Medical Examiners released the body as non-med. Dr. Kornblom

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 10020		COSTON CITY HOSP. MASS.		66 10020	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Larrintino Brown			September 30, 1966 1:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
The Johns Hopkins Hospital			Maryland		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			1033 North Central Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Negro	Single (child)	10/1/64	1	
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Leo			Mary Morrison		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Sept 29 19 66 to Sept 30 19 66, that (I) (we) last saw the deceased alive on Sept 30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Mardelle Buss M.D.				9-30-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Mardelle Buss		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
		10/3/66		ANATOLIAN CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 5 1966		Robert E. Farber		MORTUARY SERVICE - BCHD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-10021		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66-10021	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy Storms		2. DATE AND HOUR OF DEATH Sept-23-1966 11 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital		A. STATE B. COUNTY 105			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore MD			
5. SEX Male		6. RACE white		D. STREET ADDRESS (If rural, give location) 105 Patterson Place	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 9-21-66		9. AGE (In years last birthday) 55.37	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME William C. Storms		14. MOTHER'S MAIDEN NAME Elizabeth A. Jones			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 773.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Hyaline Membrane Disease (B) E pneumoniae (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 21 19 66 to Sept. 23 19 66, that (I) (we) last saw the deceased alive on Sept 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodelio M. Lim		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-23-66	
23C. PHYSICIAN'S NAME (Type) Rodelio M. Lim		23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/3/66		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	

11 A

Walters M.D.

Chloroform & Alcohol

White

White

9-21-00

Elizabeth A. Jones

William C. Jones

Hyaline Membrane  
Disease  
- Pneumocystis pneumonia

Sept 23

Sept 31

Sept 23

Respiratory  
System

9-21-00

Chloroform & Alcohol

28504-520

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10022				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10022	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Daniel Jones</b>				2. DATE AND HOUR OF DEATH <b>9-19-66</b> <b>3 36 PM</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
D. STREET ADDRESS (If rural, give location) <b>Baltimore City Hospitals</b> <b>4940 EASTERN AVENUE</b> <b>#21224</b>				5. SEX <b>Male</b>			
6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated (M)</b>		8. DATE OF BIRTH <b>4-25-80</b>		9. AGE (In years last birthday) <b>86</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL JONES</b>				14. MOTHER'S MAIDEN NAME <b>SRAH BENNETT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH 4940 EASTERN.AVE.</b>		ADDRESS <b>#21224 BALTO., MD.</b>	
18. <b>332X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vasc. Thrombosis</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-13</b> 19 <b>34</b> to <b>9-19</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>9-19-</b> 19 <b>66</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William A. Emerson</b> M.O.				23B. DATE SIGNED <b>9-19-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM A. EMERSON</b> M.D.				23D. ADDRESS <b>4940 EASTERN AVENUE BALTO. MD. #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>101 3/66</b>		24B. DATE <b>101 3/66</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>OCT 5 1966</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>		ADDRESS	

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P-12-P

M-12

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Control Area

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P-12-P

P-12-P

P-12-P

11

P-12-P

William A. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-17720 66 10023		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10023	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>BABY BOY COLEMAN</u>			8/28/66 11:45AM. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSP, OF MARYLAND</u>			A. STATE B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, MARYLAND</u>			D. STREET ADDRESS (If rural, give location) <u>3410 BATEMAN AVENUE</u>		
5. SEX <u>MALE</u>	6. RACE <u>N</u>	7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>BETTY JEAN COLEMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <u>768.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>SEPSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PREMATURITY</u>			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <u>39 hrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 28</u> 19 <u>66</u> to <u>Sept 28</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>Sept 28</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. S. Reroma</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>F. S. Reroma</u>				23D. ADDRESS <u>LUTHERAN HOSP, OF MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/29/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1966</u>		25B. NAME OF REGISTRAR <u>R. B. E. Jackson</u>		25C. FUNERAL DIRECTOR	

Black Creek

Black Creek

Black Creek



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10024	
BIRTH NO. 66-19839		66 10024		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY BOY (B) McQUEEN		2. DATE AND HOUR OF DEATH 9/11/66 1:45 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL OF MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 16-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD. 21216 D. STREET ADDRESS (If rural, give location) 2503 WINCHESTER AVE			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTO, MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ELIJAH L. McQUEEN			14. MOTHER'S MAIDEN NAME FRANCES TRIPPS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 776X I IMMATURITY		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 hrs. n	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/10/66 19 to 9/11/66 19 that (I) (we) last saw the deceased alive on 9/11/66 1:45 A.M. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. McQueen				23B. DATE SIGNED 9/11/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. LUTHERAN HOSPITAL OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/29/66		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town or county) (State)		24E. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			

DATE: 1944

1944

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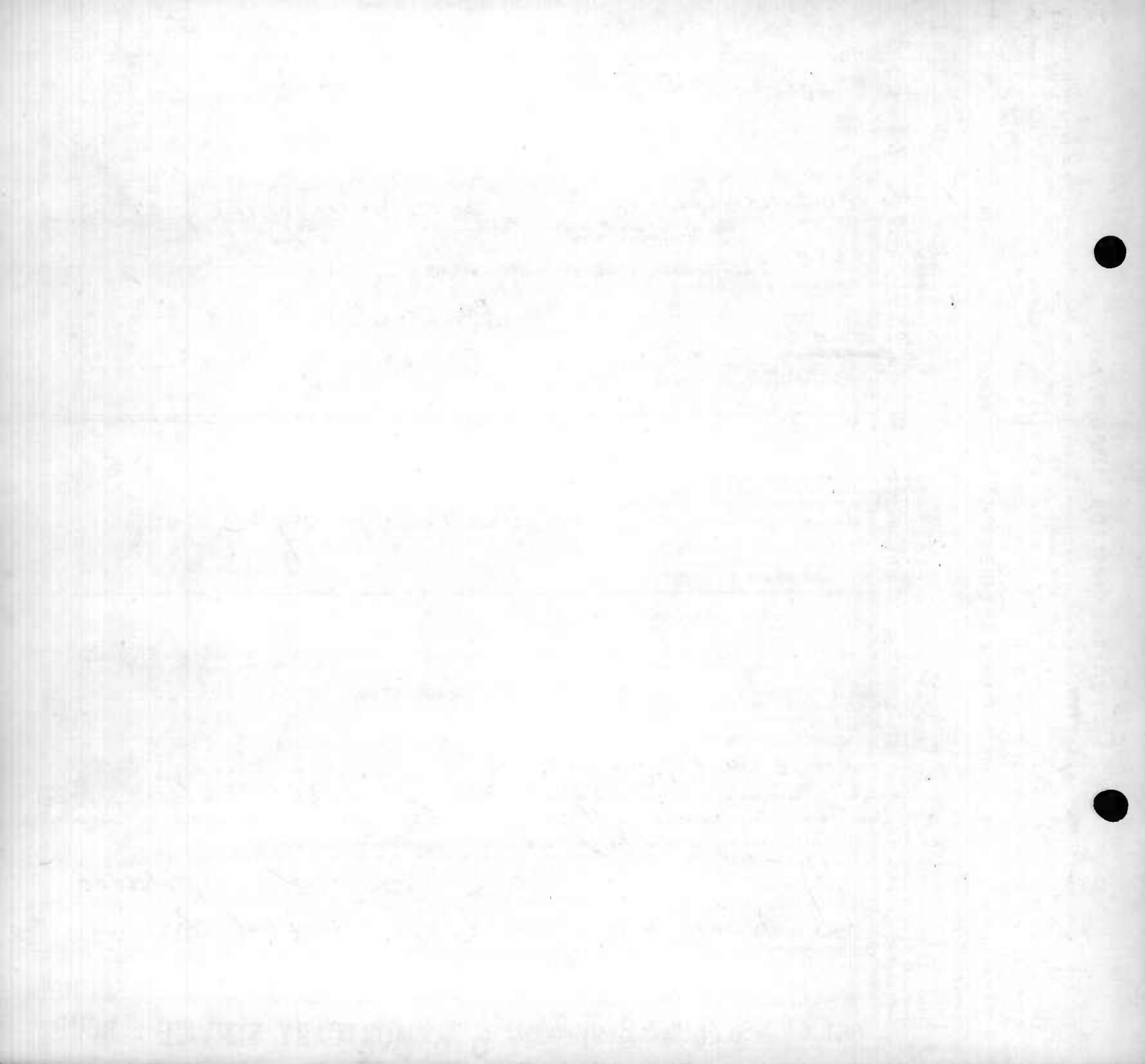
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10025				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10025	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>McQueen, Baby "A"</i>				2. DATE AND HOUR OF DEATH <i>9-16-66 1 6<sup>00</sup> P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <i>LUTHERAN HOSPITAL</i>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE, MD 21216</i>			
				D. STREET ADDRESS (If rural, give location) <i>3503 WINCHESTER ST</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTO. MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ELIJAH</i>				14. MOTHER'S MAIDEN NAME <i>FRANCES L. Tripps</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <i>768.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) DUE TO <i>Renal artery</i> (B) DUE TO <i>Overwhelm: p sepsis</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <i>Sept. 16 1966 6:10 PM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9/10</i> 19 <i>66</i> to <i>9/16</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (I) (did) (did not) view the body after death.							
23A. SIGNATURE <i>SK</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/16/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>S. KIM, M.D.</i>				23D. ADDRESS <i>Lutheran Hospital, Baltimore MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>9/29/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ANATOMY BOARD OF MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Oct 5 1966</i>		25C. FUNERAL DIRECTOR <i>Johns Hopkins Medical School</i>			
MORTUARY SERVICE - BCHD							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10026</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.5em;">66 10026</span></span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Gertrude Jean Reichenberg</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 2, 1966</span> <span style="float: right;">5:25 A. M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">South Baltimore General Hospital</span>			A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 30</span>		
<span style="font-size: 1.2em;">43</span>			D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1459 Towson Street-<del>112</del> #30</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">October 14, 1921</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">44</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife - Welder Bethlehem Steel</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Virginia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">America (U.S.)</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">James Lindsay (deceased)</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">May Dee Gooden (deceased)</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">219-20-5381</span>		17. INFORMANT <span style="font-size: 1.2em;">Frank Reichenberg</span>	
				ADDRESS <span style="font-size: 1.2em;">as above</span>	
18. <span style="font-size: 1.2em;">462.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Cardiac Arrest</span> DUE TO (B) <span style="font-size: 1.2em;">Hemorrhage</span> DUE TO (C) <span style="font-size: 1.2em;">Ruptured esophageal varices</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">10-2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9-22</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">10-2</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Oct. 2</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Consolador C. Palad, Jr.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">Oct. 2, 1966</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Consolador C. Palad, Jr.</span>				23D. ADDRESS <span style="font-size: 1.2em;">South Baltimore General Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/5/66</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Cross Cemetery Baltimore, Md.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">Oct 5 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jenkins</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Charles E. Sterens Funeral Home, Inc.</span>	
				ADDRESS <span style="font-size: 1.2em;">2501 E. Fort Avenue</span>	

1. The first part of the report

is a general statement of the

work done during the year

and the results obtained

in the various branches of the

work, and a statement of the

amount of the work done

in each of the branches

of the work, and a statement of the

6-11

*[Handwritten signature]*

For the Board of Directors

1911

Released on approval of Medical Examiner  
FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 66 10027		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10027	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROBERT H. LESLEY		2. DATE AND HOUR OF DEATH 10-2-66 1 230 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4-01 D. STREET ADDRESS (If rural, give location) 2 S. Frederick St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 6-2-81	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Theatrical Showman		10B. KIND OF BUSINESS OR INDUSTRY Theatrical Business		11. BIRTHPLACE (State or foreign country) California	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 32091424		17. INFORMANT Maurice A. Ghun 2 S. Frederick St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. D MIDDLE CEREBRAL ART OCCLUSION		CAUSE OF DEATH Septicemic shock urinary tract infection Benign prostatic hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 6 days. 12 days?? years.	
19A. DATE OF OPERATION 9-26-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED IRACH - Resp distress		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-21-66 to 10-2-66, that (I) (we) last saw the deceased alive on 10-1-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jay Martin Barrash		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-2-66	
23C. PHYSICIAN'S NAME (Type) JAY MARTIN BARRASH		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE Oct. 4, 1966		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Philip E. Coach		25D. ADDRESS 1211 Chesaco Ave.			

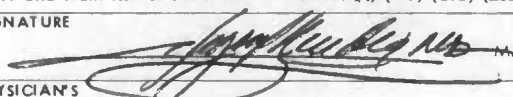






FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10028</b>	
BIRTH NO. <b>66 10028</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BLONDINA INEZ LOWE</b>			2. DATE AND HOUR OF DEATH <b>10/2/66</b>   <b>9:00</b> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b> <b>40</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>FERNDALE</b> <b>Glen Burnie</b> D. STREET ADDRESS (If rural, give location) <b>205 CHALMERS AVE.</b> <b>52-00</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6/19/21</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JAMES B. Minnish</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Jane Hicks</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-16-0558</b>	17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>3-25-X</b> <b>Or Pulmonary</b> <b>Pulmonary fibrosis &amp; Emphysema</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>9/22</b> <b>19 66</b> to <b>10/2</b> <b>19 66</b> , that (X) (we) last saw the deceased alive on <b>10/2</b> <b>19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) (not) view the body after death.					
23A. SIGNATURE  M.D.			23B. DATE SIGNED <b>10/2/66</b>		23C. PHYSICIAN'S NAME (Type) <b>MIGUEL A. HEREDIA</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>6 Oct. 66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>			25C. FUNERAL DIRECTOR <b>Glen Burnie</b>		

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1. NAME OF DECEASED (Type or Print) <b>Lester C. MANN, JR.</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 1st 1966 12:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Carroll</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>FINKSBURG 56-00</b> D. STREET ADDRESS (If rural, give location) <b>Rte 2, Finksburg</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>June 7 1940</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck-driver</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (If years lost birthday) <b>26</b>
11. BIRTHPLACE (State or foreign country) <b>Carroll Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lester C. Mann</b>		14. MOTHER'S MAIDEN NAME <b>May Ward</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>213-38-9399</b>	
17. INFORMANT <b>Lester C. Mann, Sr. Finksburg RT#2 Md.</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bilateral Bronchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Complicating Multiple Injuries</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Interval between onset and death</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>U.S. Rte 140, 4 1/2 mile west of Rte 91</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>Sept 24 1966 9:15 p.m.</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>FINKSBURG, Md. operator of motorcycle struck by car</b>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>Oct 2nd 1966</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>Oct. 4 1966</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Providence Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Finksburg R.D. #2 Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
24C. FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster, Md.</b>		ADDRESS	

66 10029 66 0030012



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10030	
BIRTH NO. 66 10030		CERTIFICATE OF DEATH		Registered No. 66 10030	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARGARET SWEENEY		2. DATE AND HOUR OF DEATH 10-3-66 3:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy		A. STATE MD. B. COUNTY A.A.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CHEN BURKIE 32-00			
		D. STREET, ADDRESS (If rural, give location) HARDING ROAD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 6-16-1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) PRINCE GEORGE CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PHILIP MORELAND		14. MOTHER'S MAIDEN NAME ELITHA GIBSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOSEPH SWEENEY EDGEMATER MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Heart Failure, 2 MI.			
ANTECEDENT CAUSES		(B) DUE TO Lobes Pneumonia.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Grand mal Seizures			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/1/66 19 to 10/3/66 19, that (I) (we) last saw the deceased alive on 10/3/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE [Signature]		23B. DATE SIGNED 10/3/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-6-66		24C. NAME OF CEMETERY OR CREMATORY ST. MARYS	
24D. LOCATION (City, town, or county) ANNAPOLIS		24E. (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature] ADDRESS [Address]	

Mr. J. H. ...

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10031	
BIRTH NO. 66 10031		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SUSAN GARY HANSBOROUGH		2. DATE AND HOUR OF DEATH Oct. 2, 1966 2: 45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md. B. COUNTY Washington County			
US Public Health Service Hospital Wyman Pk. Drive & 31st Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hagerstown 71-03			
		D. STREET ADDRESS (If rural, give location) 957 Preston Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7/17/44	9. AGE (In years last birthday) 22	(If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY public utility		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Hansborough			
14. MOTHER'S MAIDEN NAME Dorothy Stouffer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-46-1274		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Confluent bronchopneumonia		(A) DUE TO		Days	
Hodgkin's disease, stage 4 B		(B) DUE TO		Years	
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 7, 19 66, to Oct. 2, 19 66, that (I) (we) last saw the deceased alive on Oct. 2, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jon M. Beauchamp Surgeon (R)				23B. DATE SIGNED 10/2/66	
23C. PHYSICIAN'S NAME (Type) US PHS Hospital, Balto, Md.		23D. ADDRESS M.D. US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-5-66		24C. NAME of CEMETERY or CREMATORY Cedar Lawn Memorial Park Hagerstown, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.			

UNITED STATES DEPARTMENT OF JUSTICE

Division of Investigation

Office of the Director

Washington, D.C.

April 10, 1934

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Re:

Alvin Karpis

James Earl Ray

John Dillinger

Enc.

Copy 2

Very truly yours,

W. A. Rorer

Special Agent in Charge, Chicago Office

10-10-34

Enclosed for the Chicago Office



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 10032					CERTIFICATE OF DEATH		Registered No. 66 10032			
1. NAME OF DECEASED (Type or Print) <b>EDGAR T. McGUIRE</b>					2. DATE AND HOUR OF DEATH <b>10/2/66 1:28 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b> <b>48</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO 11-01</b> D. STREET ADDRESS (If rural, give location) <b>1323 N. CALVERT ST.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>4/10/86</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Stevens Caterers</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>THOMAS MCGUIRE</b>					14. MOTHER'S MAIDEN NAME <b>XXXXXXX ? Laura Ege</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>7</b>		17. INFORMANT <b>4905 Catalpha Rd. Alice - Mrs. Dolan.</b> ADDRESS					
18. <b>E90301</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLI</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>THROMBOPHLEBITIS</b> <b>FRACTURE OF HIP</b>					CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>					
19A. DATE OF OPERATION <b>SEPT 15 1960</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FRACTURE OF HIP</b>		20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>Frank's home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>319 E. North Ave</b>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>9/5/66</b>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Became dizzy &amp; fell</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>10/2 1966</b> and that (I) (we) lost saw the deceased alive on <b>10/2 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>[Signature]</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>10/2/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>MD General Hospital</b>					23D. ADDRESS <b>MD General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>			25B. NAME OF REGISTRAR <b>R. E. Farkas</b>			25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>			ADDRESS <b>3331 Brehms Lane</b>	

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# FUNERAL DIRECTOR: IMPORTANT

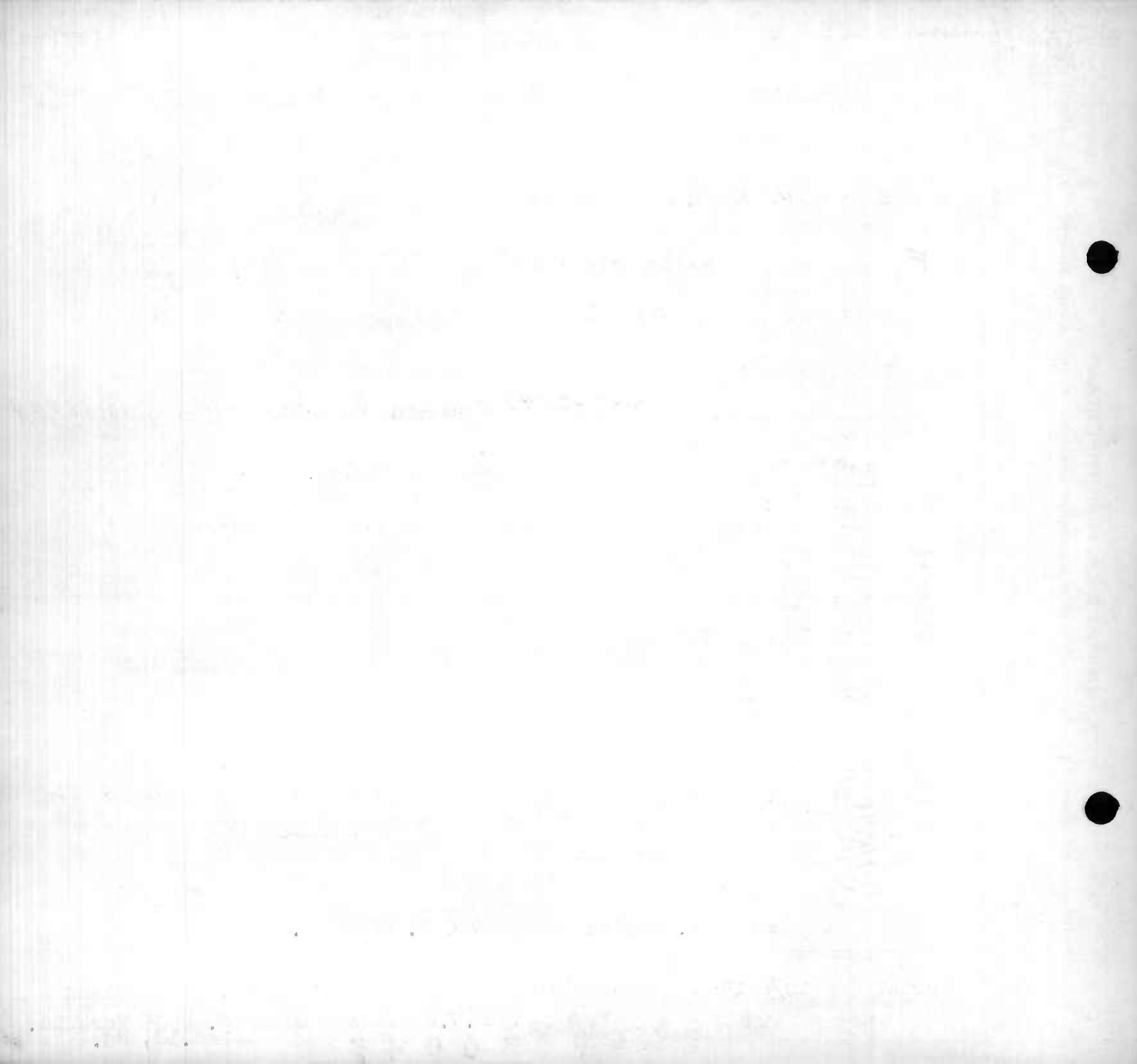
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 10033		CERTIFICATE OF DEATH		66 10033	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Alice G. Murray</i>			OCT. 3, 1966 7 <sup>45</sup> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>			A. STATE <i>Md.</i> B. COUNTY		
10-11-66			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 27-0121213</i>		
D. STREET ADDRESS (If rural, give location) <i>2826 Kentucky Ave. 27-01</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>10/14/90</i>	9. AGE (In Years last birthday) <i>75</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John C. Murray</i>			14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth McDermott</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-10-2782</i>	17. INFORMANT ADDRESS <i>Medical records</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12-15 hrs.</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>ASCD</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <i>8-11</i> 19 <i>66</i> to <i>10-3</i> 19 <i>66</i> , that (I) <u>we</u> last saw the deceased alive on <i>10-3</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard D. Shuger</i>				23B. DATE SIGNED <i>10/3/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard David Shuger</i>				23D. ADDRESS <i>Mercy Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/6/66</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fidler</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>	
				ADDRESS <i>3331 Brehms Lane</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10034</u>	
BIRTH NO. <u>66 10034</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Trenholm, Miss Julia Chisolm</u>		2. DATE AND HOUR OF DEATH <u>10-4-66</u> <u>4<sup>45</sup> P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>91 KESWICK NURSING HOME</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1300 W. 40th ST</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>2-4-1878</u>	9. AGE (In years last birthday) <u>88 yrs</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Glover Trenholm</u>			14. MOTHER'S MAIDEN NAME <u>Julia Chisolm</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>316-46-6949</u>	17. INFORMANT <u>Edward Gieske - 1021 WINDING WAY</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (B) <u>Generalized arteriosclerosis</u> DUE TO (C) <u>14th terminal episode</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 24 1964</u> to <u>4 Oct 1966</u> , that (I) (we) last saw the deceased alive on <u>4 Oct 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harold P. Breice</u>				23B. DATE SIGNED <u>4 Oct 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harold P. Breice</u>				23D. ADDRESS <u>700 W. 40th St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/6/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>			



P-653

66 10035

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10035

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Garnett M. Prentis

2. DATE AND HOUR PRONOUNCED DEAD

10/3/66 2:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 230 Stoney Run Lane

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 12-01

D. STREET ADDRESS (If rural, give location)

230 Stoney Run Lane

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

5/18/1925

9. AGE (In years  
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Self-employed

10B. KIND OF BUSINESS OR INDUSTRY

Interior Decorating

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Morton M. Prentis

14. MOTHER'S MAIDEN NAME

Frances Celeste Lusk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL  
SECURITY NO.

213-28-4453

17. INFORMANT

H. Spencer Everett, Jr., 7 E. Redwood St.

ADDRESS

18. E871.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypoxic brain damage due to acute alcoholic  
DUE TO and barbiturate intoxication

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN DETERMINING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

230 Stoney Run La. 12-01

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 2 66 ?

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

ingested barbiturates and alcohol

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/4/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

10/5/1966

23C. NAME of CEMETERY or CREMATORY

Greenmount

23D. LOCATION

(City, town, or county)

Baltimore

Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 5 1966

24B. NAME OF REGISTRAR

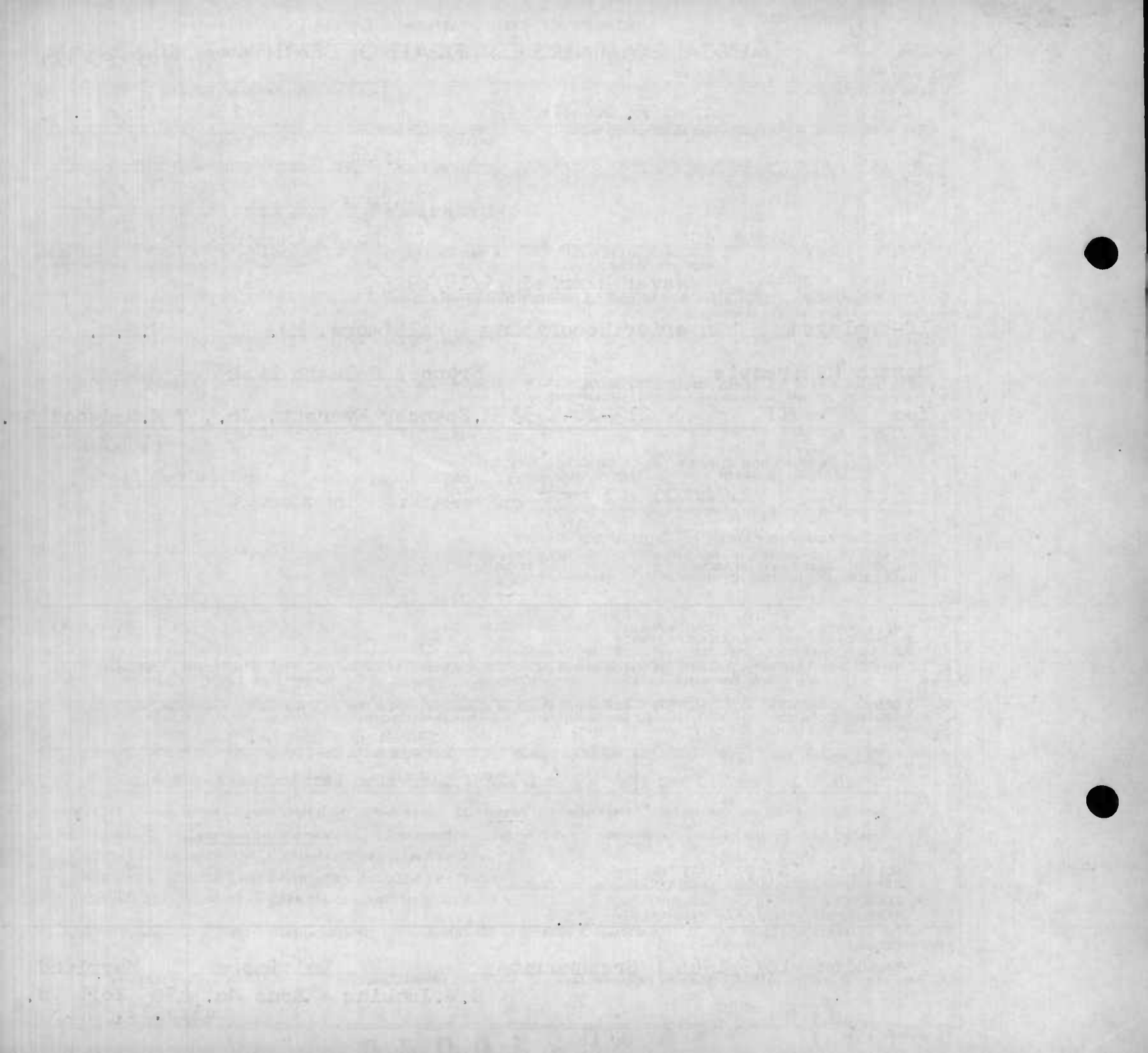
Robert E. Farkas

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.  
Balto. 12, Md.

ADDRESS



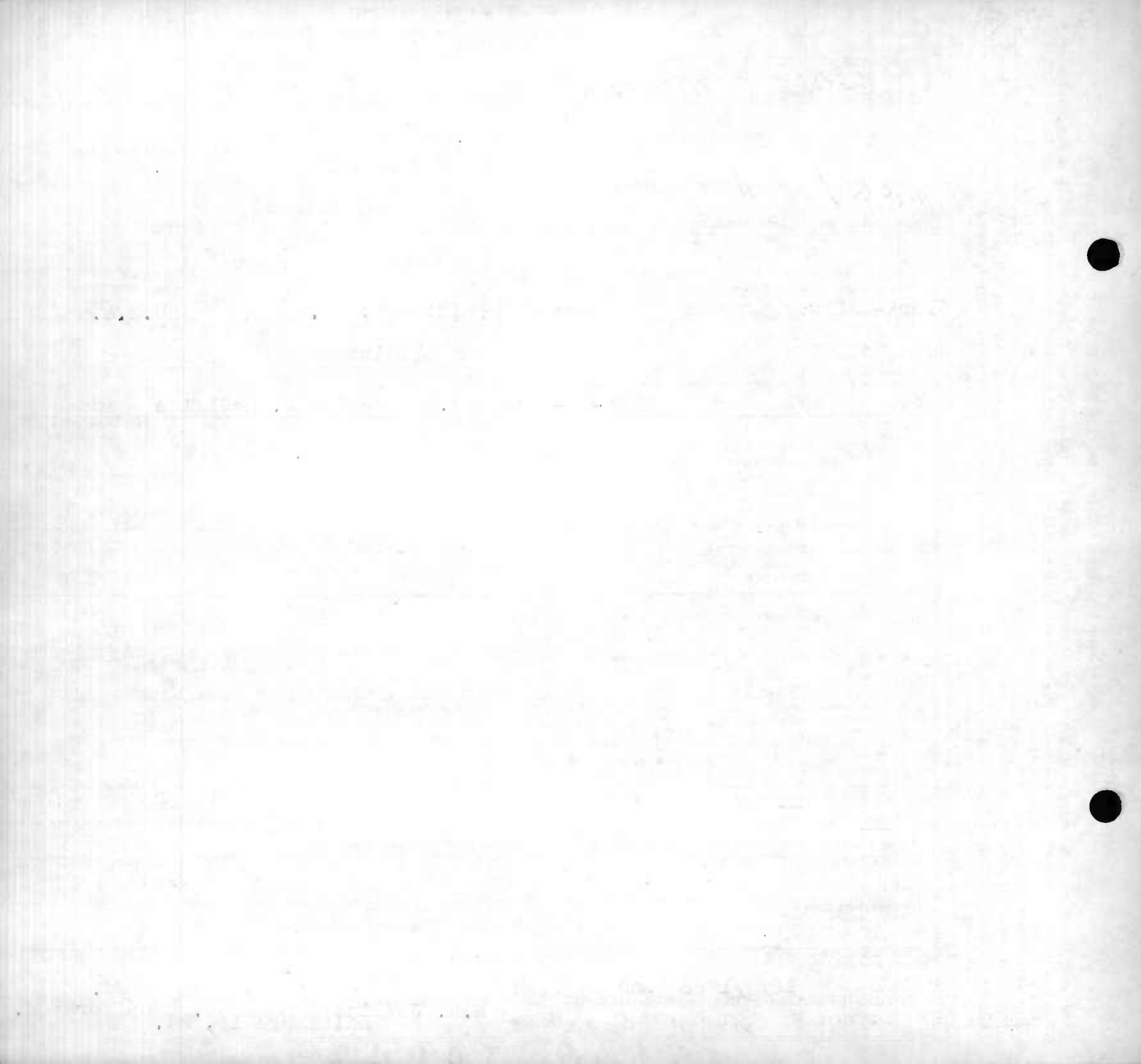




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10036		BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10036	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GEORGE T. McCLAIN</b>				2. DATE AND HOUR OF DEATH <b>10-4-66 8<sup>30</sup> P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore 18</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>9-02</b>			
D. STREET ADDRESS (If rural, give location) <b>1501 Medford Road</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/4/1895</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Railway Express Office</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Office</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John McClaine</b>				14. MOTHER'S MAIDEN NAME <b>Ann Elloit</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>714-10-2516</b>		17. INFORMANT <b>Mrs. Marguerite C. McClaine (Same)</b>			
18. <b>177X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Metastasis of CA prostate g/ 4mo.</b>		CAUSE OF DEATH (A) DUE TO <b>pneumonia, Renal failure 3WK</b> (B) DUE TO <b>CA prostate g/end more than 4mo.</b> (C)		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. CAUSE OF UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>10/2/1966</b> to <b>10/4/1966</b> , that (I) (we) last saw the deceased alive on <b>10/4/1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>NARONG RUANGRUCHIRA</b> M.D.				23B. DATE SIGNED <b>10/4/66</b>		23C. PHYSICIAN'S NAME (Type) <b>NARONG RUANGRUCHIRA</b> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkley</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co., 1905 York Rd. Baltimore 12, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10037		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10037	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>NELSON - ANDERSEN</b>		2. DATE AND HOUR OF DEATH <b>10-3-66 9:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp.</b>		D. STREET ADDRESS (If rural, give location) <b>216 W. Madison St.</b>		11-03	
5. SEX <b>M</b>	6. RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>4-15-87</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician - Med. - City Hosp.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York City</b>	
12. CITIZEN OF WHAT COUNTRY? <b>America</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>152-16-4414</b>		17. INFORMANT ADDRESS <b>Mrs. Helen L. Anderson (Same)</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia &amp; Acute C.T. Bleeding</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO <b>Metastatic Ca of Liver</b>		(B) DUE TO <b>Cancer of Colon, rectum</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>22 Sept. 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Anterior Resection of Sigmoid Colon</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>17 Sept. 1966</b> to <b>3 Oct. 1966</b> , that (I) (we) last saw the deceased alive on <b>3 Oct. 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hyong Sok Lee</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>HYONG SOK LEE,</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>10/6/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Fairview</b>	
24D. LOCATION (City, town, or county) (State) <b>Westfield, N. J.</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25D. ADDRESS <b>4905 York Balto. 12, Md.</b>		25E. DATE <b>OCT 5 1966</b>	

Version - 4/25/87

Green Memorial Hwy.



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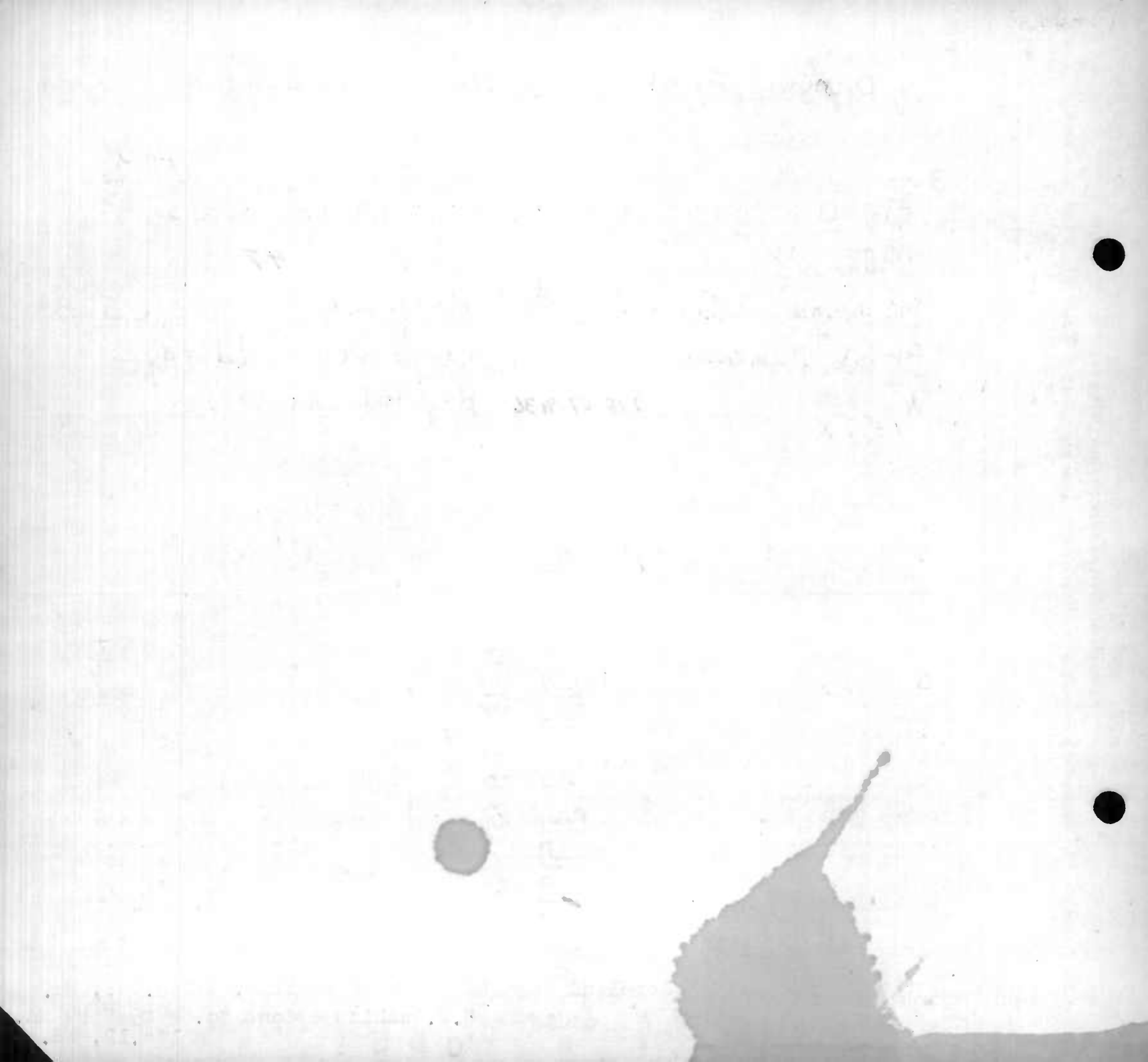
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10038				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 10038	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Duncan, Frank Annan Jr.</u>		2. DATE AND HOUR OF DEATH <u>Oct. 2, 1966</u> <u>9:00 A.M.</u>			
3. PLACE OF DEATH BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 Franklin Square Hospital</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>27-10</u>					
				D. STREET ADDRESS (If rural, give location) <u>5215 Vanhol Ave 12</u>					
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>8-25-1919</u> <u>47</u>		9. AGE (in years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic - Auto - Sherwood</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>PLYMOUTH H</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Frank A. Duncan</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Willbridge</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-07-9136</u>		17. INFORMANT <u>Hospital chart</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>157X I</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <u>Pulmonary Edema</u> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Carcinoma Pancreas</u> DUE TO				?	
				(C) <u>Generalized Carcinomatosis</u> DUE TO				?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 27</u> 19 <u>66</u> to <u>Oct. 2</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 2</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. ( <u>9:00 am 10-2-66</u> )									
23A. SIGNATURE <u>K. B. Lee</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/2/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>Ki Bum Lee</u>				23D. ADDRESS <u>Franklin Square Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/6/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Parkville, Balto. Co., Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Balto. 12, Md</u>			

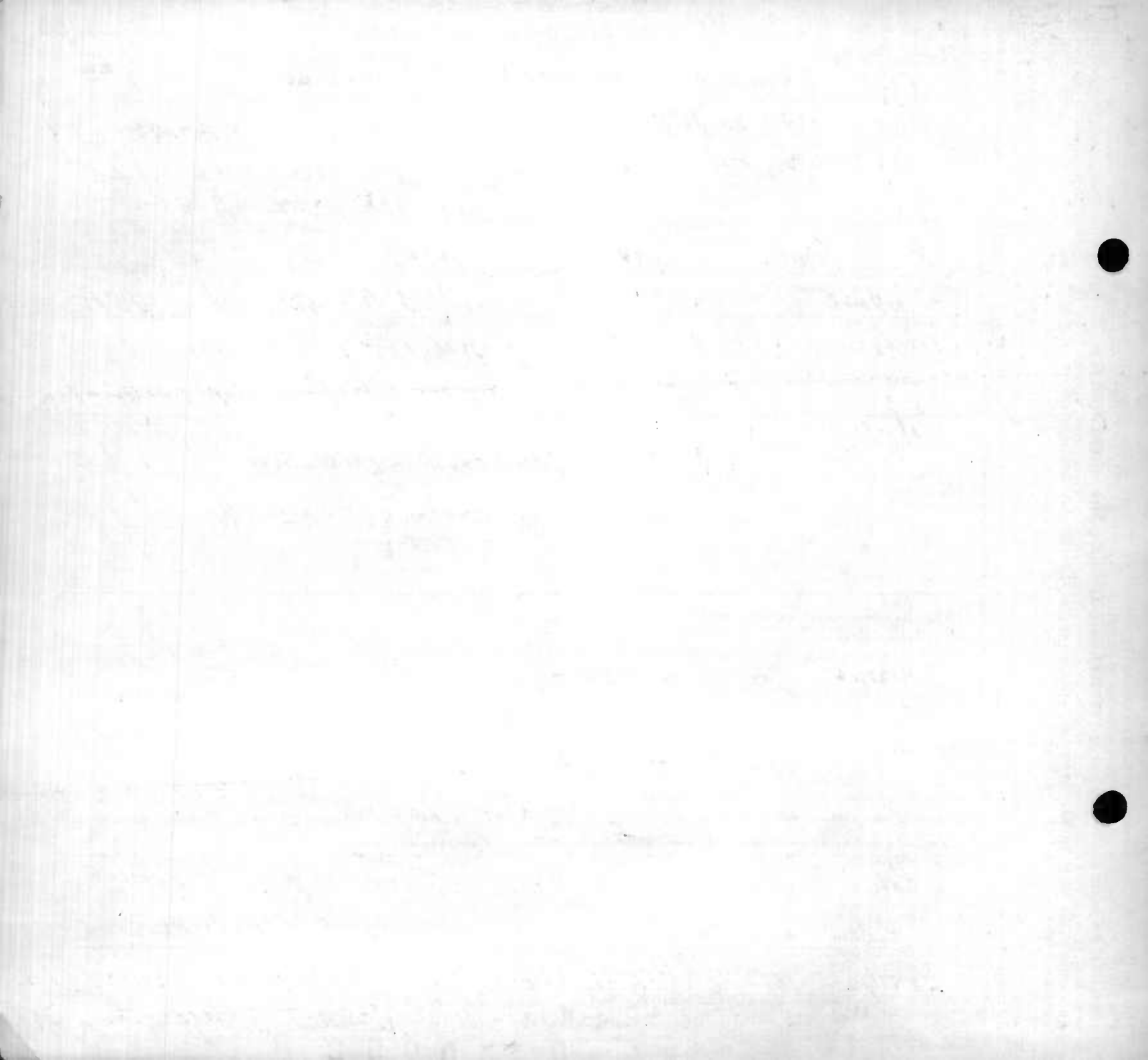


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10039		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10039	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FISH, SAVANNAH ELIZABETH		2. DATE AND HOUR OF DEATH 10-2-66 7:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND UNIVERSITY HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTE (If not in hospital or institution, give street address or location) BALTIMORE, Md		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY 12-03 D. STREET ADDRESS (If rural, give location) 319 ILICHESTER AVE			
5. SEX F	6. RACE Conc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIV.	8. DATE OF BIRTH 7/30/07	9. AGE (In years last birthday) 39	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA - Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME C. ALBERT GAYLOR			14. MOTHER'S MAIDEN NAME MARGARET E. WOLFORD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MR. LOUIS E. FISH, BALTIMORE, MD.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) ARTERIOLECTIC CARDIOVASC. DISEASE DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 days.	
19A. DATE OF OPERATION 3/9/20/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RELEASE OF ADHESIONS.		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NA		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NA	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NA		21E. INJURY OCCURRED While At <input checked="" type="checkbox"/> NA Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NA	
22. I certify that (A) (this hospital) attended the deceased from SEPT 20 19 66 to OCT 2 19 66, that (B) (we) lost saw the deceased alive on 7:00 2 OCT 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert M. Benzley		M.D. Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2 OCT 66	
23C. PHYSICIAN'S NAME (Type) ROBERT M. BENZLEY		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/5/66		24C. NAME of CEMETERY or CREMATORY BEAVER CREEK CEM, WASHINGTON COUNTY MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR W. J. Kornum, Hagerstown, Md.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10040		CERTIFICATE OF DEATH		Registered No. 66 10040	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Florence Hankins Buckalew</i>		2. DATE AND HOUR OF DEATH <i>Oct 4 1966</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Gould Convalesorium</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Kingsville - Rural</i>		53-00	
6116 - Belair Rd, Baltimore 21206		D. STREET ADDRESS (If rural, give location) <i>Bellvue Ave</i>			
5. SEX <i>F</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>May 16, 1889</i>	9. AGE (In years lost birthday) <i>77 years</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dressmaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Seamstress</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	
12. CITIZEN OF <i>U.S.A.</i>		13. FATHER'S NAME <i>Richard Hankins</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth (Unknown)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No (unknown)) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>143-05-3465</i>		17. INFORMANT <i>Charles Buckalew</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>422.1</i>		CAUSE OF DEATH <i>Hypostatic Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		<i>Uremia</i>		<i>Chr. Arteriosclerotic Cardiovascular Disease</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>None</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March</i> 1966 to <i>Oct 4</i> 1966, that (I) <i>(X)</i> last saw the deceased alive on <i>Sept 5</i> 1966 and that in <i>(my)</i> <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Willard P. Hudson</i> M.D.				23B. DATE SIGNED <i>10/4/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>WILLARD P. HUDSON M.D.</i>				23D. ADDRESS <i>FOREST HILL, MD.</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 6, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Woodbine Cemetery</i>	
24D. LOCATION <i>Long Branch, New Jersey</i>		24E. FUNERAL DIRECTOR <i>Earl H. Walbert</i>		24F. ADDRESS <i>6306 - Belair Rd - Baltimore 21206 Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 6 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. ADDRESS <i>6306 - Belair Rd - Baltimore 21206 Md</i>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10041	
BIRTH NO. 66 10041				CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Feige, Henry William			2. DATE AND HOUR OF DEATH 6.00 PM, Oct. 2, 1966 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital 44			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 816 East Lake Avenue. 27-48		
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 08-09-96	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during last 12 months, if retired) Employed Retired		10B. KIND OF BUSINESS OR INDUSTRY Oil Co.		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME William E. Feige, Jr.			14. MOTHER'S MAIDEN NAME Ada Myer (MEYER)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 216-05-2602	17. INFORMANT Mrs. A. KATHERINE FEIGE		ADDRESS Same
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Cerebral apoplexy DUE TO (B) Hemorrhagic congestion of lungs DUE TO (C) coronary heart disease		INTERVAL BETWEEN ONSET AND DEATH 20 hours U.K. Bin
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2.00 PM Oct 1 1966 to 6.00 PM Oct 2 1966, that (I) (we) last saw the deceased alive on 5.40 PM Oct 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Song Won Song			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Oct 2, 1966
23C. PHYSICIAN'S NAME (Type) Dr. Song Won Song			23D. ADDRESS M.D. The Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/6/66	24C. NAME of CEMETERY or CREMATORY Lakeview Mem. Park		24D. LOCATION (City, town, or county) (State) Balto
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1966		25B. NAME OF REGISTRAR R. E. Farley, Jr.		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, Inc. 6500 York Road, 21212	

Father Henry William

The Union Memorial Hospital

M. White Married

Retired

William A. Feige

Maryland  
Baltimore  
818 East Lake Avenue

08-09-96 to

Maryland

Adm. Myer (over)

Mrs. A. Katherine Feige

Cerebral Sphincter

Robert Oct 22

Hand from dog

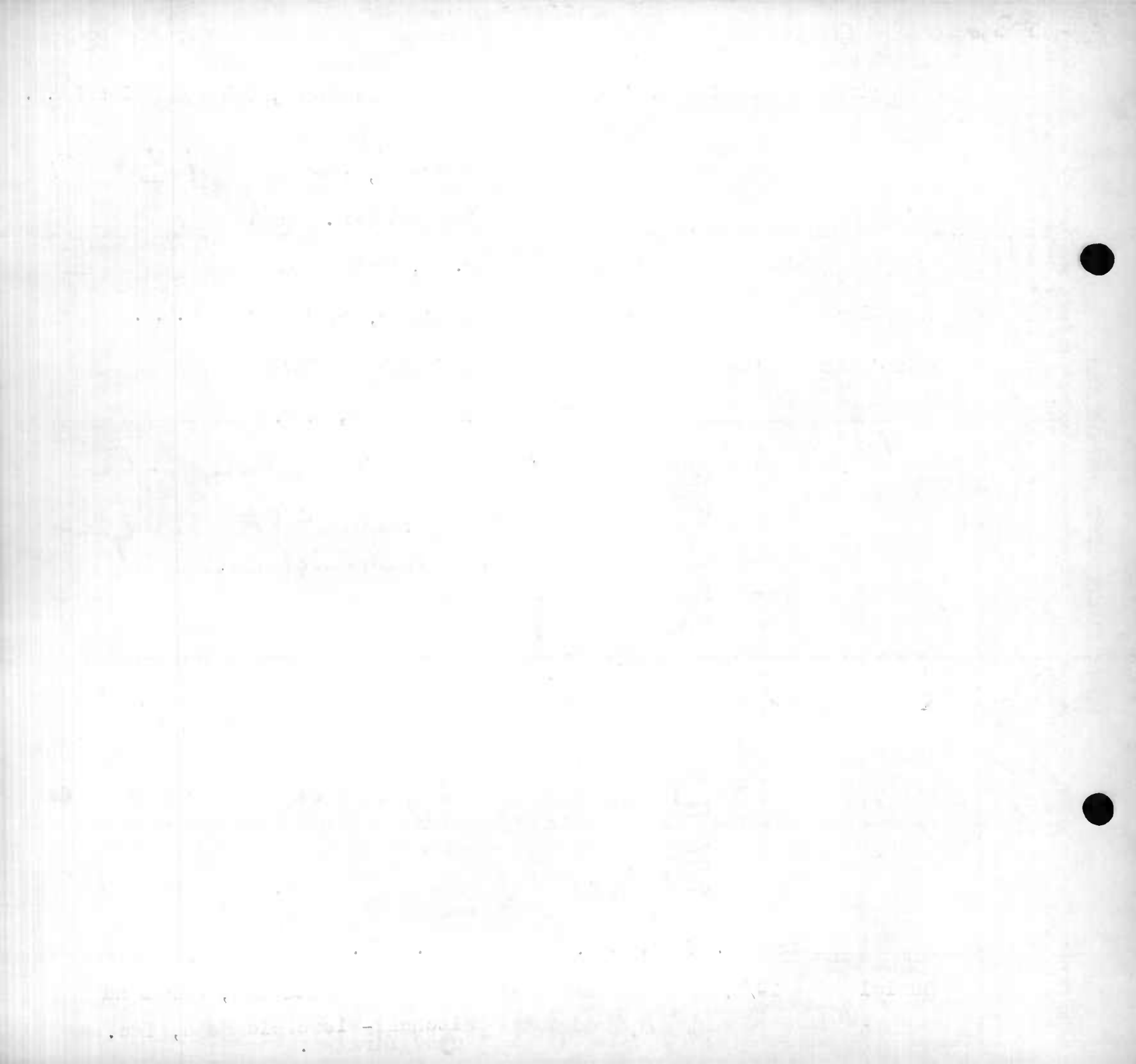
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <b>66 10042</b>				
BIRTH NO. <b>66 10042</b>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>Miss Florence Ella LeMaitre</b>					2. DATE AND HOUR OF DEATH <b>October 1, 1966 10:00 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>91 KESWICK</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>KESWICK</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Maryland</b> D. STREET ADDRESS (If rural, give location) <b>700 West 40th. Street</b>				
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>Mar. 30, 1876</b>	9. AGE (In years last birthday) <b>90</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John George LeMaitre</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Davey</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-05-1451</b>		17. INFORMANT <b>Helen Keller, R. N.</b>			ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Coronary Thrombosis</b> DUE TO (B) <b>Arteriosclerotic CVD</b> DUE TO (C) <b>Gen. Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>					19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>August 19 66</b> to <b>1 Oct 1966</b> , that (I) (we) last saw the deceased alive on <b>10 Oct 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Harold P. Biehl</b> M.D.					23B. DATE SIGNED <b>1 Oct 66</b>			23C. PHYSICIAN'S NAME (Type) <b>Harold P. Biehl, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>10/3/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6300 York Rd.</b>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 10043</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 10043</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MILLER, JAMES FRANK</b>			2. DATE AND HOUR OF DEATH <b>10-02-66 9:45 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTO., MD. 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CATONSVILLE, 21228</b> D. STREET ADDRESS (If rural, give location) <b>608 FREDERICK ROAD</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>02-10-99</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Worked in Printing Shop News papers</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>XXX USA</b>
13. FATHER'S NAME <b>JAMES W. MILLER</b>			14. MOTHER'S MAIDEN NAME <b>BESSIE (CAVEY)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>217-09-0927</b>		17. INFORMANT ADDRESS <b>XXXXXX ST. AGNES RECORDS</b>
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Metastatic Carcinoma of the</b> DUE TO <b>legion</b> (B) <b>Carcinoma of the</b> DUE TO <b>lung</b> (C) <b>lung</b>  INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPT. 14, 1966</b> to <b>OCT. 2, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCT. 2, 1966</b> and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Manuel Jimenez</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>10 2 66</b>
23C. PHYSICIAN'S NAME (Type) <b>MANUEL JIMENEZ</b>			23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVES BALTO., MD. 21229</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/5/1966</b>	24C. NAME of CEMETERY or CREMATORY <b>St. Johns Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>		25B. NAME OF REGISTRAR <b>Polym E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Easton Funeral Home Catonsville, Md.</b>	

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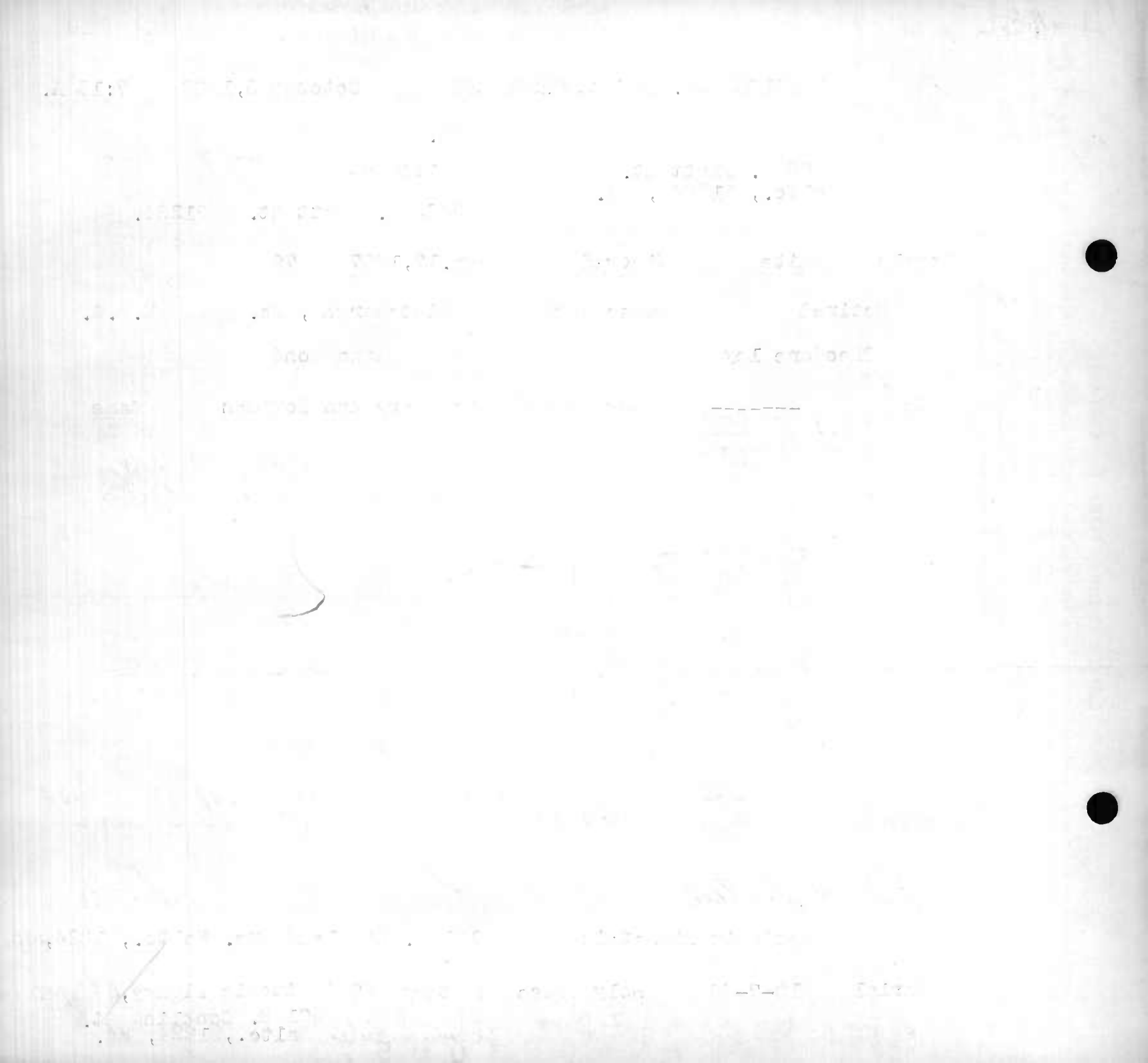
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

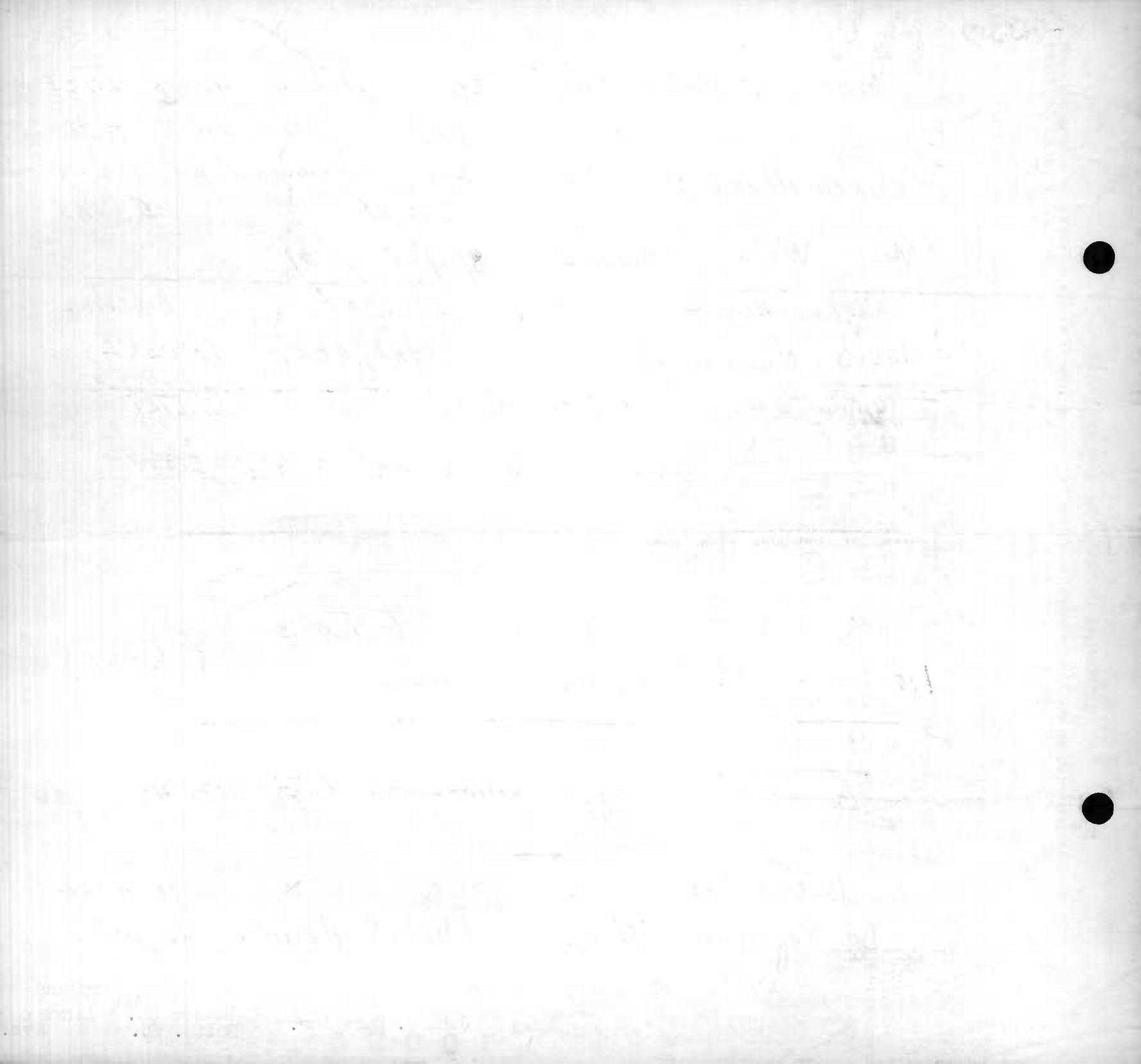
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10044</u>	
BIRTH NO. <u>66 10044</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MATILDA W. HOFFMAN*HOFFMANN</u>		2. DATE AND HOUR OF DEATH <u>October 5, 1966</u>   <u>7:15 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HDSPITAL DR INSTITUTION <u>00</u>		(If not in hospital or institution, give street address or location) <u>3425 E. Pratt St. Balto., 21224, Md.</u>		A. STATE <u>Md.</u> B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3425 E. Pratt St. # 21224.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 17, 1887</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Theodore Ley</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bond</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-8253</u>		17. INFORMANT <u>Miss Mary Ann Hoffman</u>	
				ADDRESS <u>Same</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>GENERAL THROMBOSIS</u> <u>ARTERIOLECTIC C.V. D.S</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>10 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>10/4/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> 19 <u>68</u> to <u>10/5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/4/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B. Highstein</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Benjamin Highstein</u>		23D. ADDRESS <u>121 S. Highland Ave. Balto., 21224, MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-7-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>6020 Ritchie Hwy. A.A.C., MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Benjamin Highstein</u>	
				ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10045</b>	
BIRTH NO. <b>66 10045</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Nowowieski, Walter Joseph SR.</b>		2. DATE AND HOUR OF DEATH <b>OCTOBER 4, 1966 8:05 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>35 Church Home &amp; Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE Balt County</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>325 TOWNSEND Rd 21221</b> D. STREET ADDRESS (If rural, give location) <b>ESSEX 53-00</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/15/85</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>
13. FATHER'S NAME <b>JACOB Nowowieski</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET PRUSKA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO. <b>213-07-5869</b>		17. INFORMANT ADDRESS <b>FRANCES Nowowieski</b>
18. <b>43-0-1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>GANGRENE, INTESTINES</b>					
19A. DATE OF OPERATION <b>11-3-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LOWER GANGRENE</b>		20A. AUTOPSY? (Yes or No) <b>REFUSED</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 2 1966</b> to <b>OCT. 4 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT. 4 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>asternlo</b>				23B. DATE SIGNED <b>10-4-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Raymond ATKINS</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/8/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>		25C. FUNERAL DIRECTOR <b>John J. Duda Inc.</b>		ADDRESS <b>Hudson St. &amp; Linwood Balto. Md. Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	66 10046
BIRTH NO. 66 10046				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HATTIE V. FOARD</b>			2. DATE AND HOUR OF DEATH <b>10:25 AM 10-2-66</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>House of the Pines Belair</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>5837 Belair Rd</b> <b>90 BALTIMORE, MD 21206</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> <b>53-00</b>		
5. SEX <b>Female</b> 6. RACE <b>white</b> 7. MARRIED, NEVER MARRIED, DIVORCED (specify) <b>WIDOWED</b>			8. DATE OF BIRTH <b>4 October 1880</b> 9. AGE (In years last birthday) <b>85</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		
11. BIRTHPLACE (State or foreign country) <b>BALTO, MD Dist Washington</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JOHN R. Smith</b>			14. MOTHER'S MAIDEN NAME <b>SARAH V. GATES</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-46-0709</b>		
17. INFORMANT <b>Mrs Reba Finney 2403 Taylor Avenue</b>			ADDRESS		
18. <b>422.141-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ATHEROSCLEROTIC Cardiovascular Dis - undet</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. <b>DIABETES MELLITUS Pyritic</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>40 yrs 2 wks.</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION <b>10-2-66</b>			21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21F. HOW DID INJURY OCCUR?		
21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>January 1964</b> to <b>10-2-1966</b> , that (I) (we) last saw the deceased alive on <b>29 October 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John C. Hyle</b>			23B. DATE SIGNED <b>10-3-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>			23D. ADDRESS <b>2527 Belair Rd Balto 36.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10-5-1966</b>		
24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore Md. MD</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		
25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>			ADDRESS <b>(34)</b>		



THE UNIVERSITY OF CHICAGO

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

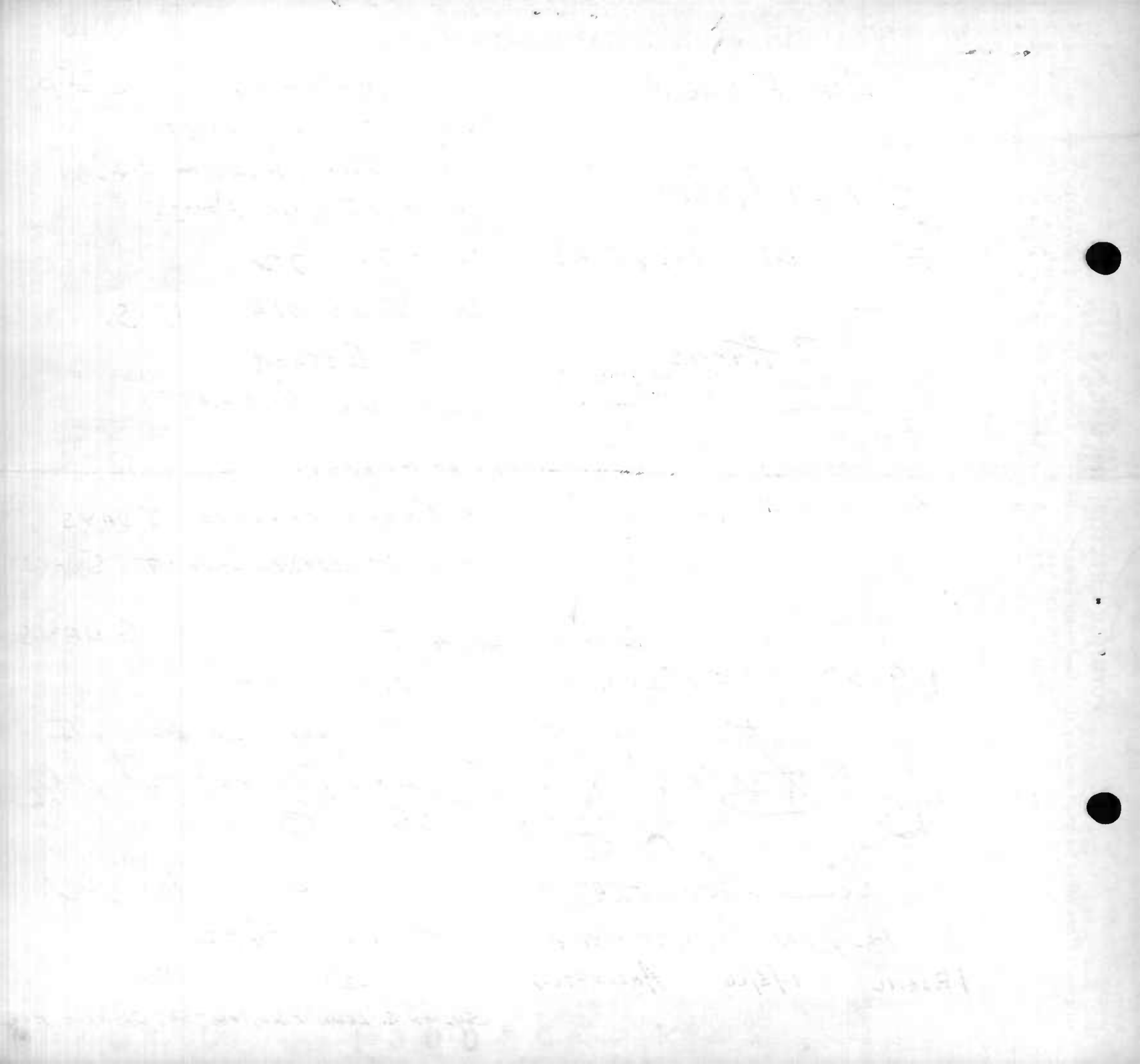
BIRTH NO. 66 10047		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 10047	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>FRANCES M. Mac DONALD</b>			2. DATE AND HOUR OF DEATH <b>10/4/66 2:55 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Johns Hopkins Hospital</b> <b>33</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3501 St. Paul Street</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>10/14/1902</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traffic Clerk</b>			11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM MAC DONALD</b>			14. MOTHER'S MAIDEN NAME <b>FRANCES BOURKE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>084-01-1046</b>		17. INFORMANT ADDRESS <b>Jeannette MacDonald 3501 St. Paul St.</b>
18. <b>199.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Asphyxia &amp; Respiratory Arrest</b> DUE TO (B) <b>Adenocarcinoma (? primary)</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>9/18</b> 19 <b>66</b> to <b>10/4</b> 19 <b>66</b> , that (we) last saw the deceased alive on <b>10/4</b> 19 <b>66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James J. Allen</b>				23B. DATE SIGNED <b>10/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES J. ALLEN</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn, New York</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Elbert H. Unsworth 4600 Liberty Hgts.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE-CITY HEALTH DEPARTMENT										
BIRTH NO. 66 10048					CERTIFICATE OF DEATH		Registered No. 66 10048			
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <b>IDA FISHER</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					2. DATE AND HOUR OF DEATH <b>10-3-66 4:35 P.M.</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSP.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 13-01</b>					
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>					D. STREET ADDRESS (If rural, give location) <b>TEMPLE GARDEN APTS.</b>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					8. DATE OF BIRTH <b>1-1-94</b>			9. AGE (In years last birthday) <b>72</b>		
10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>? HARRIS</b>					14. MOTHER'S MAIDEN NAME <b>? ESTHER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL CHART.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>420141E903.0</b>					CAUSE OF DEATH <b>CARDIAL ARREST.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>0</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO <b>ACUTE RENAL FAILURE 5 DAYS</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					DUE TO <b>ACUTE MYOCARDIAL INFARCT 5 DAYS</b>					
19A. DATE OF OPERATION <b>1-9-27</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FX (L) HIP</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Temple Garden Apts</b>			
21D. TIME OF INJURY (APPROX.) <b>7/27/66 ? AM</b>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell out of chair + tripped</b>			
22. I certify that (I) (the hospital) attended the deceased from <b>9-27-66</b> to <b>10-3-66</b> and that (I) (we) last saw the deceased alive on <b>10-3-66</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above: (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Alvin Schachter</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-3-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>ALVIN SCHACHTER</b>					23D. ADDRESS <b>SINAI HOSP.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/5/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON</b>		24D. LOCATION (City, town, or county) (State) <b>BELTO MD</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>			25C. FUNERAL DIRECTOR <b>SYLVAN S. LEWIS + Son, Inc.</b>			ADDRESS <b>100-3319 OLYMPIA AVE</b>	



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66 10049

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10049

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JUDITH AMBROSE				2. DATE AND HOUR PRONOUNCED DEAD October 4, 1966 5:33 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1315 Pentridge Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Aug 24, 1938	9. AGE (In years last birthday) 28	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK CITY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT DR STEPHEN AMBROSE		ADDRESS SAME	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia DUE TO Hanging DUE TO INTERVAL BETWEEN ONSET AND DEATH							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes- Partial		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Clinic, Johns Hopkins Hospital			
21D. TIME OF INJURY (APPROX.) 10 4 '66 P M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Hanged self			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Rudiger Breitenecker</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/5/66							
23A. BURIAL CREMATION, REMOVAL (Specify) Cremation		23B. DATE Oct 7, 1966		23C. NAME OF CEMETERY or CREMATORY London Park		23D. LOCATION (City, town, or county) (State) Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT. Oct 8 1966		24B. NAME OF REGISTRAR Robert E. Taylor, MA		24C. FUNERAL DIRECTOR Sylvan S. Lewis & Son		ADDRESS 3319 Olympia Ave	

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VALLEY FORGE

DEAD

NEW YORK CITY

OF 1793

AND 1794

2000

DR. STEVEN HARRISON

+



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CO. 1ST REGT. PENN. ARTY.

FILE

Regiment's Museum



E-524 66 10050

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10050

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CLINTON W. ENGLEHART

2. DATE AND HOUR PRONOUNCED DEAD

October 3, 1966 9:26 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33/44 Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore County

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Route 4 Box 431

21227

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

9-3-1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR INDUSTRY

U. S. COAST GUARD

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

HERBERT ENGLEHART

14. MOTHER'S MAIDEN NAME

LILLIAN A. DUVALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

705-03-5332

17. INFORMANT

ADDRESS

MRS. MARGARET M. ENGLEHART, SAME AS 4-D

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 3, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-6-66

23C. NAME of CEMETERY or CREMATORY

MEADOWRIDGE CEMETERY

23D. LOCATION (City, town, or county)

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

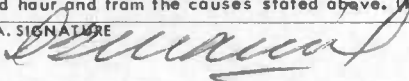
24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229

SECRET

This certificate must be given by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <b>66 10051</b>	
BIRTH NO. <b>66 10051</b>		1. NAME OF DECEASED (Type or Print) <b>HENTHORN, JAMES EDWARD, SR.</b>								2. DATE AND HOUR OF DEATH <b>10-2-66 6:30 M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 29</b> D. STREET ADDRESS (If rural, give location) <b>4413 WILKENS AVE.</b>						
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <del>XXXXXX</del> <b>1-23-93</b>	9. AGE (In years last birthday) <b>73</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>JAMES HENRY</b>				14. MOTHER'S MAIDEN NAME <b>SARAH E. WA HERS</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>705 05 0909</b>		17. INFORMANT ADDRESS <b>AVE., BALTO. 29, MD.</b>					
18. <b>446X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <b>Arterio-sclerosis with</b> <b>anemia</b> (B) DUE TO <b>Calcific aortic stenosis with</b> <b>valvular regurgitation</b> (C) <b>Right branch tree pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>10-2-</b> 19 <b>66</b> to <b>10-2-</b> 19 <b>66</b> , that <b>XX</b> (we) last saw the deceased alive on <b>10-2-</b> 19 <b>66</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) <b>XXXX</b> view the body after death.											
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/3/66</b> #29					
23C. PHYSICIAN'S NAME (Type) <b>R. MARIN</b>		23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVE</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-6-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE</b>							

ST. JOHN'S HOSPITAL, 1000 10TH AVE. S.W.

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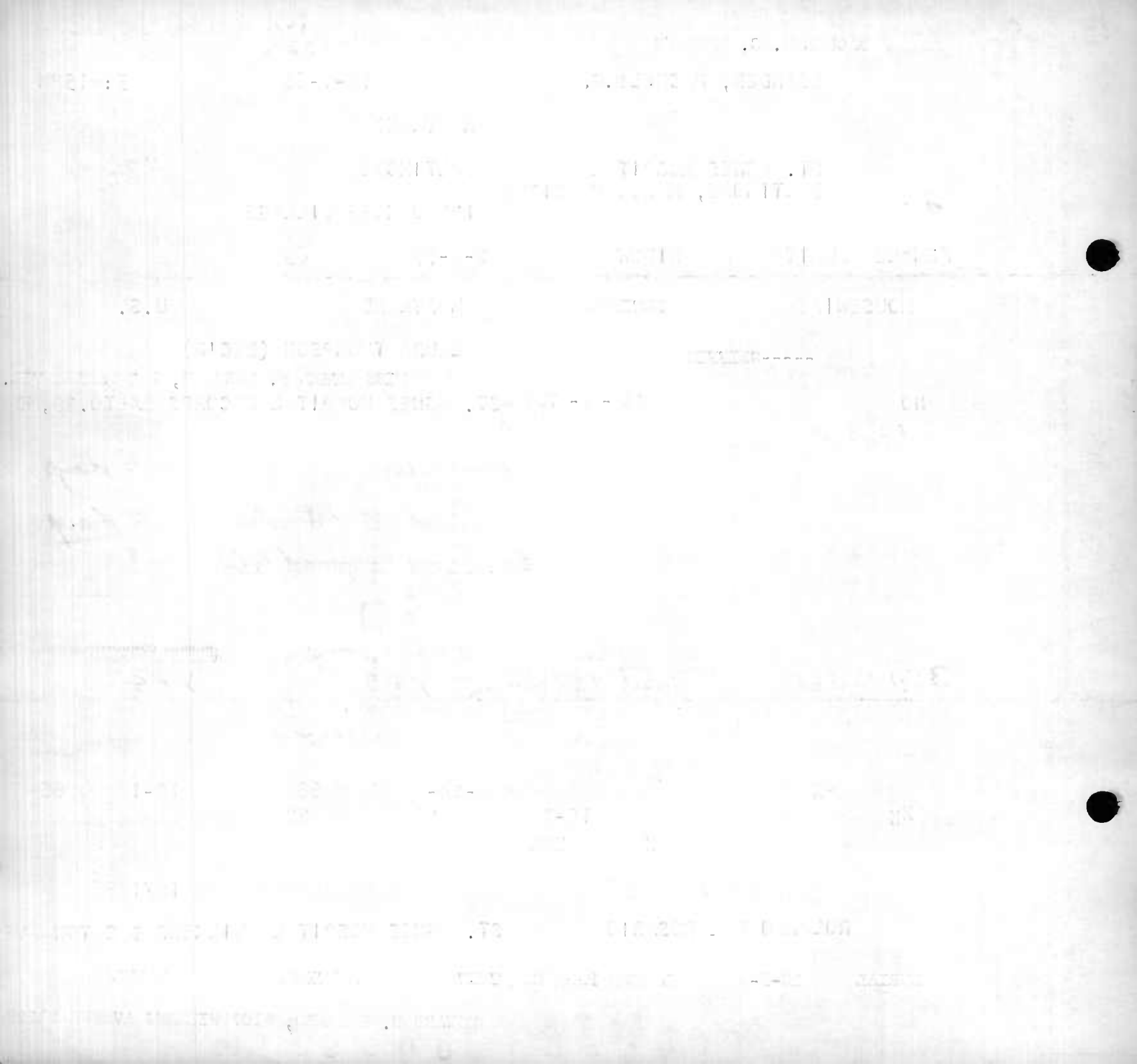
ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 10052 CERTIFICATE OF DEATH					Registered No. 66 10052				
BIRTH NO. 66 10052 M.E. CASE NO. RACHEL E. G. ESENDER 1. NAME OF DECEASED (Type or Print) ESENDER, RACHEL E.G.					2. DATE AND HOUR OF DEATH 10-1-66 5:15PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  40 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTIMORE, MARYLAND 21229					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 162 OAKLEE VILLAGE				
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH 2-9-77		9. AGE (In years last birthday) 89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME -----GRIFFIN					14. MOTHER'S MAIDEN NAME LAURA THOMPSON (DEC'D)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-09-8784 D		17. INFORMANT MISS ETHEL M. ESENDER, 162 OAKLEE VIL. ST. AGNES HOSPITAL RECORDS BALTO. 29, MD			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERESTED OBSTRUCTION 5 days DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERESTED OBSTRUCTION 8 days DUE TO CARCINOMA SIGMOID COLON ? DUE TO									
19. DATE OF OPERATION 24 Sept 66 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTERESTED OBSTRUCTION 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO				21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 9-24-19 66 to 10-1-19 66, that (X) (we) last saw the deceased alive on 10-1-19 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (not) view the body after death.									
23A. SIGNATURE Rolando Del Rosario						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/1/66	
23C. PHYSICIAN'S NAME (Type) ROLANDO DEL ROSARIO				23D. ADDRESS M.D. ST. AGNES HOSPITAL WILKENS & CATON AVE					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-5-66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY			24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Howard H. Hubbard			25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10053</u>
BIRTH NO. <u>66 10053</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Ernest R. Schneider</u>		
2. DATE AND HOUR OF DEATH <u>10-2-1966</u>		M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> 10-11-66 <u>4499</u> Union Memorial Hospital D.O.A.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt. Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>700 Elmwood Road #6</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6-23-1894</u>	9. AGE (In years last birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millright Ret.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Western Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John F. Schneider</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah Jane Francis</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-01-3389</u>		17. INFORMANT <u>Mrs Catherine Schneider</u> ADDRESS <u>700 Elmwood Road</u>		
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO (B) <u>Coronary Thrombosis</u> DUE TO (C) <u>Arteriosclerotic Cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>45 minutes</u>				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>1957</u> to <u>10-2-1966</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>8-29-1966</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.				
23A. SIGNATURE <u>Paul G. Mueller</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10-4-66</u>
23C. PHYSICIAN'S NAME (Type) <u>PAUL G. MUELLER</u>		23D. ADDRESS M.D. <u>6411 Belair Rd Baltimore Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-5-1966</u>	24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>OCT 6 1966</u>	25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Lassahn Funeral Home 740 Belair Road (36)</u>		

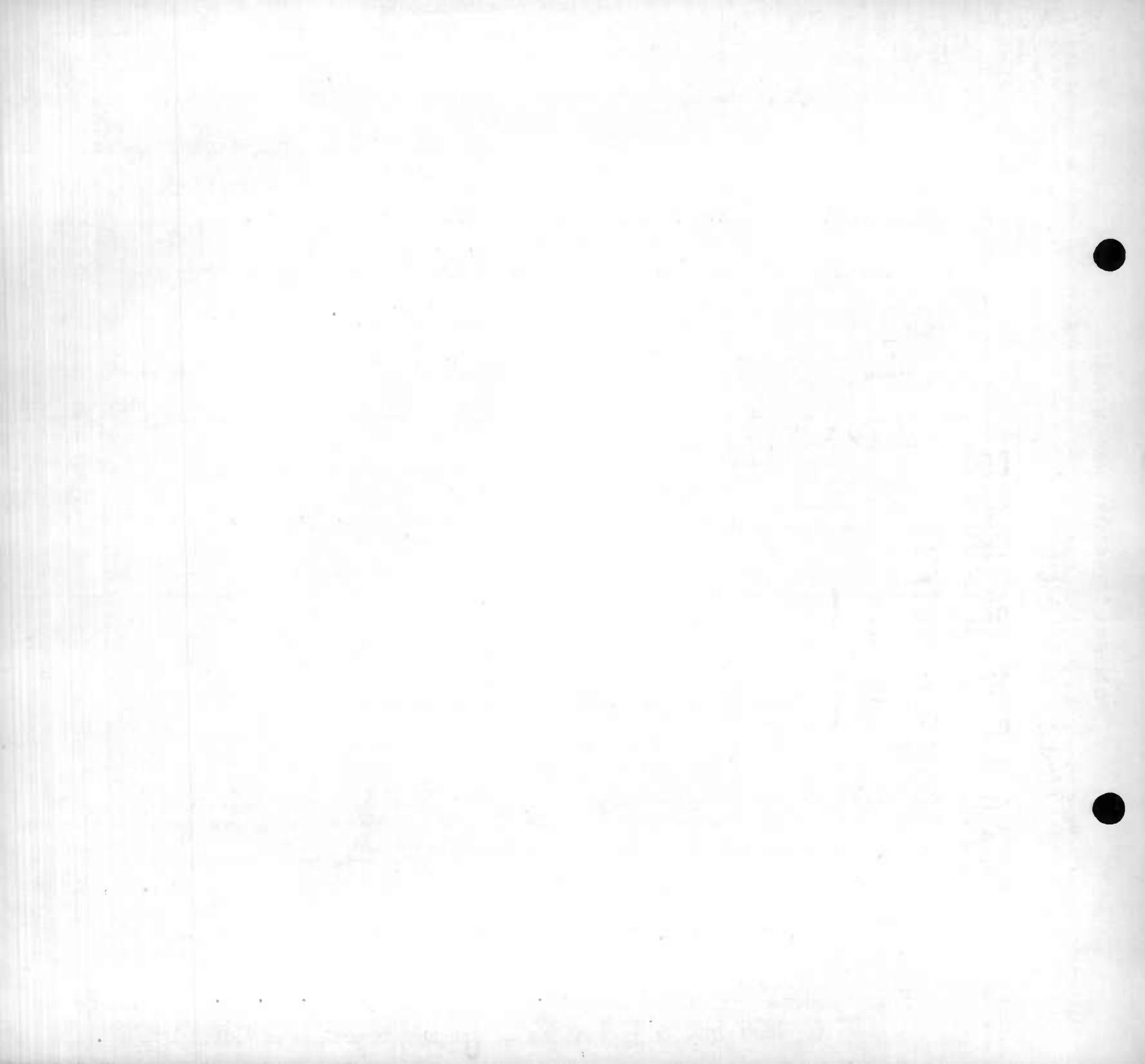




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10054				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10054	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>AGNES H REIN</u>				2. DATE AND HOUR OF DEATH <u>10/1/66</u> <u>7 30 P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> <u>House in Pines Belvedere</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4317 Marble Hall Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Wid</u>	8. DATE OF BIRTH <u>2/14/1879</u>	9. AGE (In years lost birthday) <u>87</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Healey</u>			14. MOTHER'S MAIDEN NAME <u>Brigid Sweeney</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Thelma R Schweizer</u>			
				ADDRESS <u>4220 Lochraven Blvd</u>			
18. <u>480X 1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) <u>Pneumonia</u> DUE TO <u>Flu</u> (B) <u>Arteriosclerosis</u> DUE TO <u>and</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>506 yr</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 13 1966</u> to <u>Oct 4 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 3 1966</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lester N. Kolman</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Oct. 5, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Lester N. Kolman</u>		23D. ADDRESS <u>3700 Park Heights Avenue</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/8/66</u>	24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>			
				ADDRESS <u>7101 Balair Rd.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

66 10055

BIRTH NO.

66 10055

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Julius M. Astfalk

2. DATE AND HOUR OF DEATH

September 24, 1966

5 P.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

00 2914 Hollins Ferry Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2914 Hollins Ferry Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
never married

8. DATE OF BIRTH

9-3-81

9. AGE (In years  
last birthday)

84 yrs.

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Late - Julius

14. MOTHER'S MAIDEN NAME

Late - Emilie

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.  
217-05-4600

17. INFORMANT

ADDRESS

Road.

Mrs. Dorothea Sonnenleiter-2914 Hollins Ferry

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute Coronary Occlusion

(A) DUE TO Generalized Arteriosclerosis

(B) DUE TO

Senile Changes

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

MINUTES

years

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 16, 1966 to September 24, 1966,  
that (I) (we) last saw the deceased alive on September 23, 1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry Armanis M.D.

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

Sept. 26, 1966

23C. PHYSICIAN'S  
NAME (Type)

Henry Armanis

23D. ADDRESS

M.D. 1934 Wilkens Avenue

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-27-66

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 6 1966

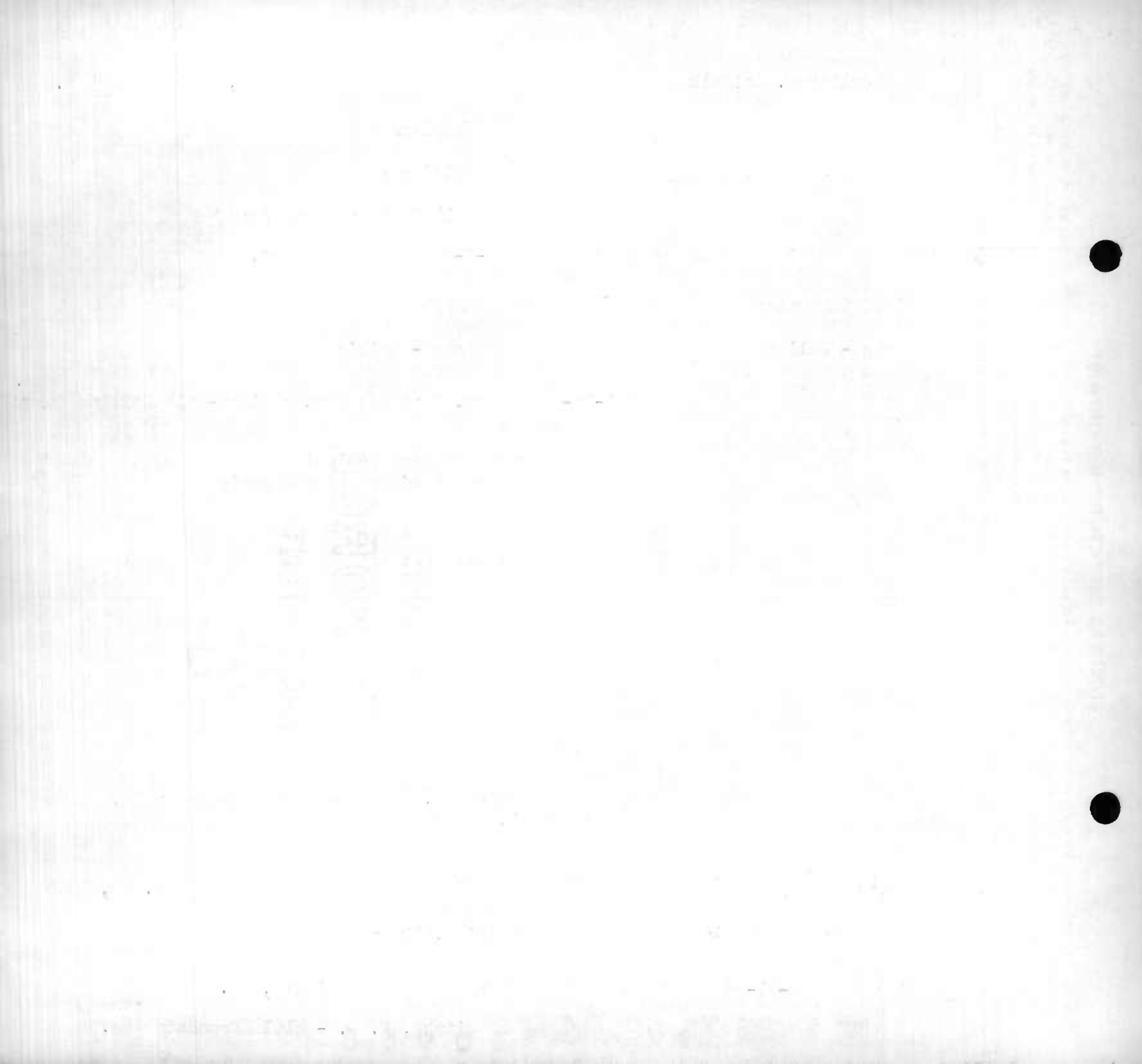
25B. NAME OF REGISTRAR

Julius M. Astfalk

25C. FUNERAL DIRECTOR

Witzke, F. D. - 4401 Edmondson Ave.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 10056	
BIRTH NO. 66 10056		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Verhina Sarda May		2. DATE AND HOUR OF DEATH 10-4-66 4:30 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				A. STATE MARYLAND B. COUNTY 3-01			
5. SEX FEMALE 6. RACE NEGRO 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED				8. DATE OF BIRTH 10-14-01		9. AGE (In years lost birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC				10B. KIND OF BUSINESS OR INDUSTRY Put Family		11. BIRTHPLACE (State or foreign country) BALTO Co. MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William CRAIG			
14. MOTHER'S MAIDEN NAME JANIE BROWN				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE. BALTO., MD.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Gram Negative Sepsis & Shock		24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Urinary Tract Infection		9 years	
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9-19-1957 19 to 10-4-66 19 that (1) (we) last saw the deceased alive on 10-4-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William A. Emerson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-4-66			
23C. PHYSICIAN'S NAME (Type) WILLIAM A. EMERSON				23D. ADDRESS BCH 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/66		24C. NAME OF CEMETERY or CREMATORY St Stephens Church		24D. LOCATION (City, town, or county) (State) Essex Balto Co. MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert G. Johnson		25C. FUNERAL DIRECTOR ADDRESS Margaret A. Hay 635 N. Gilman St			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10057		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10057	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dutton, James S.		2. DATE AND HOUR OF DEATH 10/4/66 12:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-06 D. STREET ADDRESS (If rural, give location) 639 North Rosedale Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/30/01	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10B. KIND OF BUSINESS OR INDUSTRY NITE CLUB		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Denton Dutton		14. MOTHER'S MAIDEN NAME Mary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-4616		17. INFORMANT GLADYS DUTTON 639 N ROSEDALE ST	
18. 231 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Mediastinal Tumor DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 9 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/5 19 66 to 10/4/66 19 66, that (1) (we) last saw the deceased alive on 10/4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.H. Brown, III		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/4/66	
23C. PHYSICIAN'S NAME (Type) C.H. Brown, III		23D. ADDRESS M.D. The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/8/66		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	
24D. LOCATION BALTIMORE		24E. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Maurice J. Taylor 639 N Rosedale St	

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Primer 10/10/02 14:00-15:00

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 10058		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 10058	
M.E. CASE NO.		1. NAME OF DECEASED (Type or print)		Leora Mae Brocht		2. DATE AND HOUR OF DEATH 10/4/66 @ 1:45 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		33 Johns Hopkins Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland Baltimore		5. SEX 7 F. RACE W. 6. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
None				Garrett, Penna		USA		Henry Brocht	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		14. MOTHER'S MAIDEN NAME	
No		162-16-5859		Charles Daugherty		109 Lindale Ave		Minnie Minnie Morgan	
18. 795.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		(A) DUE TO		Respiratory insufficiency many years		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		Unknown etiology (how many not known)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (the medical) attended the deceased from 9/30 19 66 to 10/4 19 66.		that (I) (the) first saw the deceased alive on 10/4 19 66 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) (not) view the body after death.							
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		10/4/66			
23C. PHYSICIAN'S NAME (Type)		DAVID L. FEDSON		23D. ADDRESS		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		Oct. 7, 66		Berlin I.O.O.F. Cem.		Berlin, Penna			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 6 1966		Robert E. Taylor		Johnson Funeral Home		Berlin, Penna			

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "bicycle" and "road" are faintly visible.]*

*It is approved by Medical Examiner*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10059		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10059	
M.E. CASE NO. KLUGA, CASPER		CERTIFICATE OF DEATH		5-8	
1. NAME OF DECEASED (Type or Print) KLUGA, CASPER		2. DATE AND HOUR OF DEATH Sept. 28, 1966 10:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL 35		A. STATE Maryland		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2-03			
		D. STREET ADDRESS (If rural, give location) 1703 S. Lancaster St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7-1-1997	9. AGE (In years last birthday) 69	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABOR		10B. KIND OF BUSINESS OR INDUSTRY MO DRY DOCK		11. BIRTHPLACE (State or foreign country) UNK.	
12. CITIZEN OF WHAT COUNTRY? UNK		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME UNK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-12-2743		17. INFORMANT ADDRESS MARIE NOVAK 7215 BROADWAY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH (A) Congestive Heart Failure 2 yrs. (B) Arteriosclerotic Heart Dis. 2 yrs. (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 28 1966 to Sept 28 1966, that (I) (we) lost saw the deceased alive on Sept 28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. Med. Director Staff Phys. [X]		23B. DATE SIGNED Sept. 28, 1966	
23C. PHYSICIAN'S NAME (Type) DENITA L. SUAREZ		M.D. Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/6/66		24C. NAME OF CEMETERY or CREMATORY St. Mathew Cem	
24D. LOCATION (City, town, or county) BALTO MD		25A. DATE RECEIVED BY HEALTH DEPT 10/6/66		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR [Signature]		ADDRESS [Signature] 1800 E Lombard St			

RECEIVED  
JAN 24 1971

Jan 24 1971

Memorandum

TO: DIRECTOR

FROM: CHURCH WOMEN

SUBJECT: 1971

DATE: 1-1-71

W M

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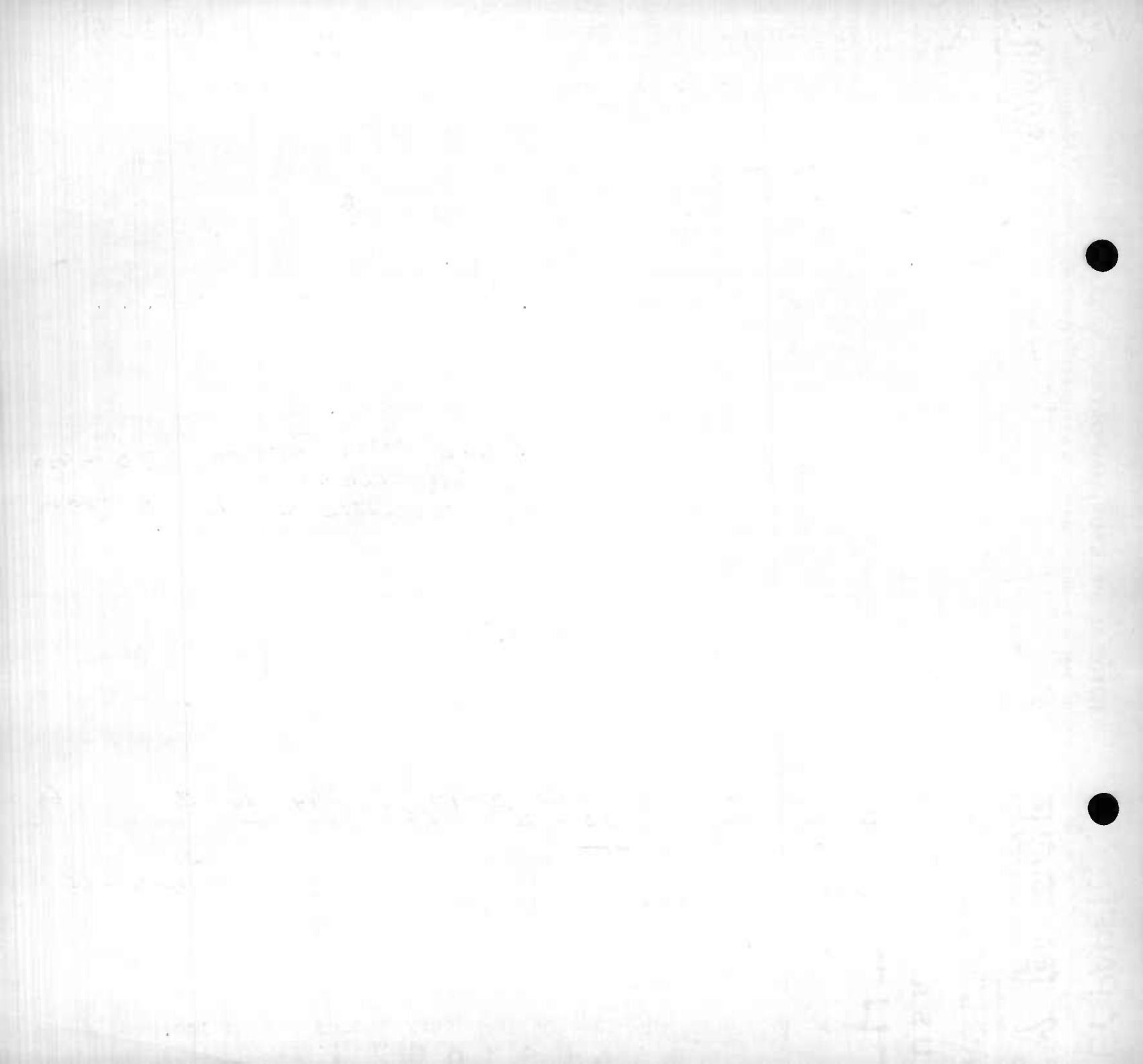
1971

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department														
BIRTH NO. 66 10060					CERTIFICATE OF DEATH					Registered No. 66 10060				
1. NAME OF DECEASED (Type or Print) <b>Haswell Roger Williams</b>					2. DATE AND HOUR OF DEATH <b>October 3, 1966 10:30a M.</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Long Green Nursing Home 115 East Melrose Avenue</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balts. C.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21212</b> D. STREET ADDRESS (If rural, give location) <b>251 Rodgers Forge Road</b>									
5. SEX <b>M.</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec. 21, 1876</b>		9. AGE (In years lost birthday) <b>89</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Retired 20 Yrs.</b>					11. BIRTHPLACE (State or foreign country) <b>Illinois</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>Douglas Williams</b>					14. MOTHER'S MAIDEN NAME <b>Alice Haswell</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>218 50 5461</b>					17. INFORMANT <b>251 Rodgers Forge Road Mrs Marie H. Williams</b>				
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Brain Syndrome Central SCLEROSIS ARTEROSCLOTIC C-V-D.</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>10 years 10 years</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NONE</b>									
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>NO</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>2-17-1944</b> to <b>10-3-1966</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>10-3-1966</b> and that in (my) ( <del>best</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was not</del> ) (did not) view the body after death.														
23A. SIGNATURE <b>Leon Ashman</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>10-4-66</b>				
23C. PHYSICIAN'S NAME (Type) <b>Leon Ashman</b>					23D. ADDRESS <b>5907 Gwynn Oak Avenue</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>10/6/66</b>					24C. NAME of CEMETERY or CREMATORY <b>Greenmount Cemetery</b>				
24D. LOCATION <b>Baltimore Maryland</b>														
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>					25C. FUNERAL DIRECTOR <b>Henry Sander &amp; Sons Inc.</b>				
25D. ADDRESS <b>Baltimore Maryland 21213</b>														





W-4201  
Body released to relatives of father.  
FURNAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10061		Baltimore City Health Department		Registered No. 66 10061	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) <i>Samantha Kay Walls</i>		2. DATE AND HOUR OF DEATH <i>3 October 1966 6:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>W. Va.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>38</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Martinsburg</i> D. STREET ADDRESS (If rural, give location) <i>107 Perry Street</i>			
5. SEX <i>White</i>	6. RACE <i>Female</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>25 Feb 1966</i>	9. AGE (in years last birthday) <i>7</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Gary David Walls</i>		14. MOTHER'S MAIDEN NAME <i>Zalma Grubb</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, rising to the above cause (A) stating UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH <i>Hydrocephalus</i> <i>congenital malformation of central nervous system</i> <i>Head trauma (by history)</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>Released</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>107 Perry St. Martinsburg, W. Va.</i>	
21D. TIME OF INJURY (APPROX.) <i>Sept 28 '66</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Pt fell from couch</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>30 Sept</i> 19 <i>66</i> to <i>3 Oct</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3 Oct</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert S. Holt</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3 Oct 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert S. Holt</i>		23D. ADDRESS M.D. <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>OCT 6 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>ROSEDALE CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>MARTINSBURG, WEST VIRGINIA</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 6 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Witzke F.D.-4101 Edmondson W.</i>		25D. ADDRESS			

WALTON



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

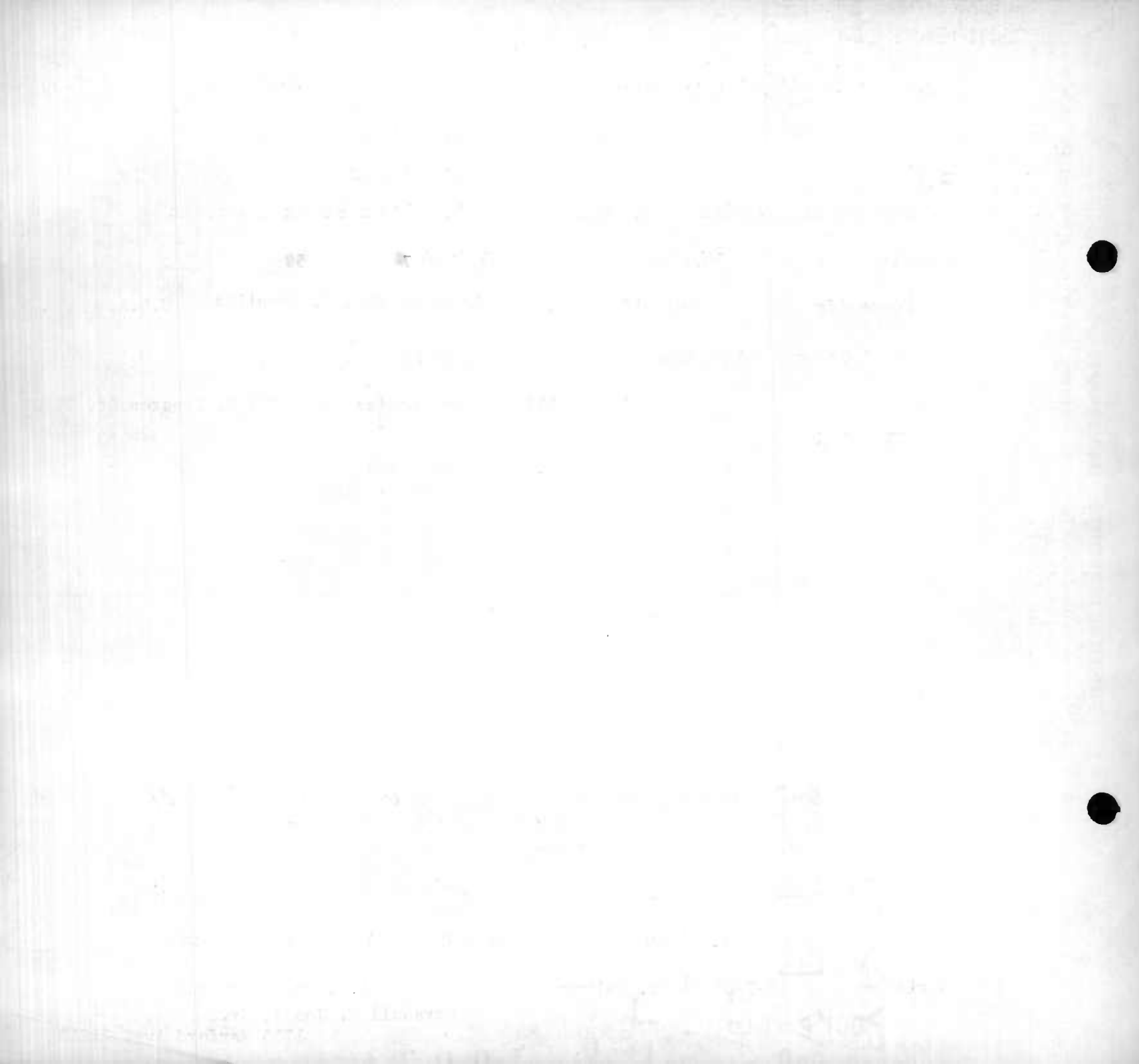
BIRTH NO. 66 10062		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 10062	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Agnes Wake Field			
2. DATE AND HOUR OF DEATH 10-3-66 11 <sup>20</sup> P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Mercy Hospital				A. STATE Md. 8. COUNTY 6-01			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 2806 E. Fairmount Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-13-08	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanislaus Potocki				14. MOTHER'S MAIDEN NAME Veronica Dkowsky			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-22-0026		17. INFORMANT ADDRESS Medical records			
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) Pulmonary edema		1-2 hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Heart and renal failure		20 days	
				(C) Diabetes mellitus, ASCVD, Kimmelstiel Wilson disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-13-1966 to 10-3-1966, that (I) (we) last saw the deceased alive on 10-3-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard D. Shuger M.D.				23B. DATE SIGNED 10-3-66		23C. PHYSICIAN'S NAME (Type) Richard David Shuger M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/7/66		24C. NAME OF CEMETERY OR CREMATORY OAKLAWN Cem.		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR B. DUBROWSKI 2415 E. BALTIMORE ST.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10063</span>	
BIRTH NO. <span style="float: right;">66 10063</span>				CERTIFICATE OF DEATH	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <span style="float: right;">LUE.</span> <b>SALLIE (Sally) Richardson</b>		
2. PLACE OF DEATH IN BALTIMORE, MARYLAND			2. DATE AND HOUR OF DEATH <span style="float: right;">10/3/66</span> <span style="float: right;">11 25 AM M.</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">33</span> <b>The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>10-01</b> D. STREET ADDRESS (If rural, give location) <b>731 East Preston Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7/28/07</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Lawrence Co., S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George Williams</b>			14. MOTHER'S MAIDEN NAME <b>Charity Duncan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>229-05-1441</b>	17. INFORMANT ADDRESS <b>Mrs. Louise Stone 731 E. Preston St. 21202</b>		
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Severe Atherosclerotic Cardiovascular Disease &amp; occlusion of renal arteries</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Rheumatic Heart Disease</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (S) (this hospital) attended the deceased from <b>9/10</b> 19 <b>66</b> to <b>10/3</b> 19 <b>66</b> , that (S) (we) last saw the deceased alive on <b>10/3</b> 19 <b>66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.					
23A. SIGNATURE <b>Murray A. Katz</b> M.D.				23B. DATE SIGNED <b>10/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Murray A. Katz</b> M.D.				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Marshall W. Jones, Jr., 1735 Harford Ave. 21213</b>			





B-250

66 10064

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 10064

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM S. Boykin

2. DATE AND HOUR PRONOUNCED DEAD

October 2, 1966 2:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1708 N. Carey Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-01

D. STREET ADDRESS (If rural, give location)

1708 N. Carey Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

2/4/1895

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Willis Boykin

14. MOTHER'S MAIDEN NAME

Catherine Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Boykin  
Sarah E. Mason 41-22 Fernhill and

ADDRESS

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Intracerebral hemorrhage  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive cardiovascular disease  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

October 3, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/6/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION (City, town, or county) (State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 6 1966

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Main St.

ADDRESS

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 10065					CERTIFICATE OF DEATH		Registered No. 66 10065		
BIRTH NO. 66 10065					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>LULA MCCARNEY</b>					2. DATE AND HOUR OF DEATH <b>10-3-66 7<sup>45</sup> A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL</b>					A. STATE <b>MD.</b> B. COUNTY <b>HAVER DE GRACE HANFORD</b>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>62-00</b>					D. STREET ADDRESS (If rural, give location) <b>Box 205 State Military Reserve</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>April 13, 1919</b>	9. AGE (In years last birthday) <b>47</b>	10. Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>WAYNESBORO, PENNA. U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>EARL H. WELTY</b>					14. MOTHER'S MAIDEN NAME <b>MABEL NEWCOMER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no -</b>			16. SOCIAL SECURITY NO. <b>191-18-3335</b>		17. INFORMANT <b>HERBERT MCCARNEY</b>		ADDRESS <b>Box 205 State Military Reserve, Haver de Grace, Md.</b>		
18. <b>330X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs.</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <b>Subarachnoid Hemorrhage</b>				
					(B) <b>Ruptured Aneurysm</b>				
					(C) <b>-</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>-</b>									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 2</b> 19 <b>66</b> to <b>Oct 3</b> 19 <b>66</b> , that (I) <u>we</u> <b>lost</b> saw the deceased alive on <b>Oct 3</b> 19 <b>66</b> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <b>(did)</b> (did not) view the body after death.									
23A. SIGNATURE <b>A. Mamaril Jr.</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>10-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANSELMO MAMARIL JR. M.D.</b>					23D. ADDRESS <b>Lutheran Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>10/4/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>PRICES</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Pa. Franklin</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher, MA</b>		25C. FUNERAL DIRECTOR <b>Walter J. Brown</b> ADDRESS <b>305 Broad St. Baltimore, Md.</b>				

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Mr. H. H. H. H.

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Box 100

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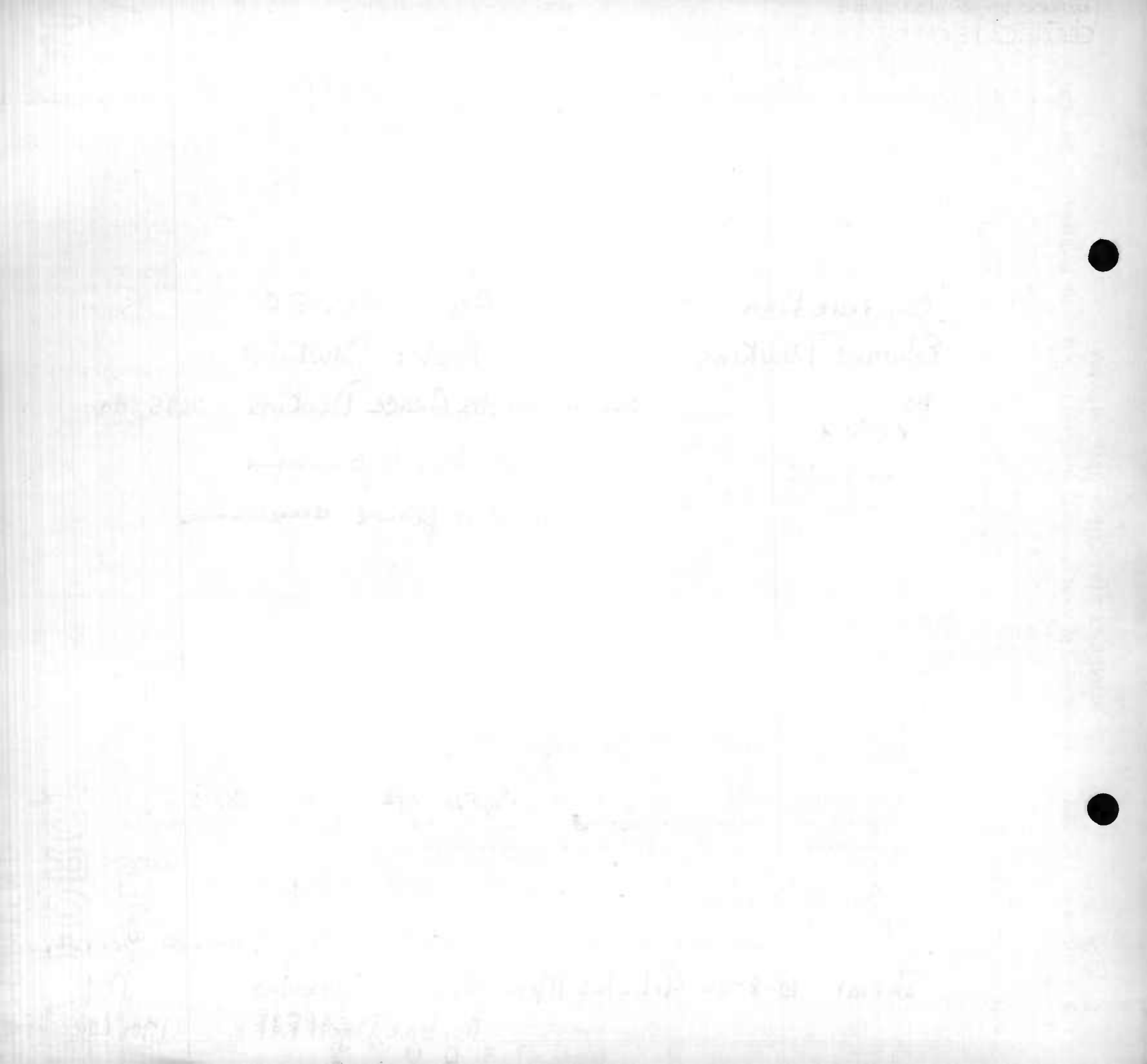
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 10066	
BIRTH NO.				66 10066	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) <u>Dawkins, Gennis</u>			2. DATE AND HOUR OF DEATH <u>10-5-66 6:20 AM</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL OF MARYLAND</u> <u>46</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>20-02</u> D. STREET ADDRESS (If rural, give location) <u>2635 EDMONDSON AVE</u>		
5. SEX <u>MALE</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8-23-1904</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Greenville, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Edward Dawkins</u>			14. MOTHER'S MAIDEN NAME <u>Hester Dawkins</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>251-09-8819</u>	17. INFORMANT <u>Mrs. Grace Dawkins</u> ADDRESS <u>2635 Edmondson</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>177X I</u> <u>Metastasis to pancreas</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prostate gland carcinoma</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH <u>4:15 AM - 6:00 AM</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPT 16, 1966</u> to <u>OCT 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT 3, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>Youngkil Kim</u>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>YOUNG KIL KIM</u>			23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-8-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION <u>Arbutus</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mortone Dgett F.H.</u>	
25D. ADDRESS <u>1701 Laurens St</u>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10067		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10067	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Ever Woodward Clayton</i>		2. DATE AND HOUR OF DEATH <i>10-5-66 5:40 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy</i>		A. COUNTY <i>Maryland</i> B. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 20-01</i> C. STREET ADDRESS (If rural, give location) <i>405 N. Loudon Ave</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9-9-1890</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>George Clayton</i>		14. MOTHER'S MAIDEN NAME <i>Annie Berke</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <i>212-32-3249</i>		17. INFORMANT <i>Mrs. Gertrude Banks</i> ADDRESS <i>405 N. Loudon</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>151X I</i>		CAUSE OF DEATH (A) <i>Respiratory Cardiac failure</i> DUE TO (B) <i>Mononuclear Carcinomatosis</i> DUE TO (C) <i>Cervical Stenosis Metastatic Bone Marrow, Liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>?</i> <i>?</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2 0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/1/66</i> 19 <i>66</i> to <i>10/5</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/5</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James A. Quinlan, Jr.</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>10/6/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JAMES A. QUINLAN JR</i>		23D. ADDRESS <i>Mary Hospital</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-10-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Nat'l</i>	
24D. LOCATION <i>Balto.</i>		24E. LOCATION <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 6 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Morton E. Dyett F.H.</i>	
25D. ADDRESS <i>1701 Laurens St</i>					



June 1st 1880

Dear

George

My dear

Yours

Very truly

Yours

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 10068	
BIRTH NO. 66 10068		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Joseph Adolph Voza		Oct. 5, 1966 3: 35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
US Public Health Service Hospital		Wyman Pk. Drive & 31st St./		NJ			
5. SEX M				6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 5/26/30				9. AGE (In years last birthday) 36		10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) NJ				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Fred Voza				14. MOTHER'S MAIDEN NAME Mary Dinicolla			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1951-1954				16. SOCIAL SECURITY NO. 151-22-4105		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Pulmonary hemorrhage, focal				Days			
Acute myelogenous leukemia				Months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr. 11 1966 to Oct. 5 1966, that (I) (we) last saw the deceased alive on Oct. 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jon M. Beauchamp, Surgeon (R)				23B. DATE SIGNED 10/6/66			
23C. PHYSICIAN'S NAME (Type) Jon M. Beauchamp, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/10/1966		24C. NAME of CEMETERY or CREMATORY St. Rose of Lima		24D. LOCATION (City, town, or county) (State) Freehold, New Jersey	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1966		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St. Baltimore, Maryland	

10/10/10

Dear Sir,

21st

London

I am writing to you

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2-10/10

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66 10069

BALTIMORE CITY HEALTH DEPARTMENT

66 10069

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RONALD James DUNCAN

2. DATE AND HOUR PRONOUNCED DEAD

September 29, 1966 6:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

517 S. Frederick Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Never Married

8. DATE OF BIRTH

apr. 1, 1941

9. AGE (In years  
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

California

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William S. Duncan

14. MOTHER'S MAIDEN NAME

Mildred Sautter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

561-56-8753

17. INFORMANT

W.S. Duncan. 252 E. California Ave.  
Pasadena, California

18.

E 974 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hanging.  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Hospital

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

University Hospital

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 29 '66 P

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Hanged self.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
9/30/6623A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

10-6-1966

23C. NAME of CEMETERY or CREMATORY

Green Mount

23D. LOCATION

(City, town, or county) Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 6 1966

24B. NAME OF REGISTRAR

Robert E. Talley, M.D.

24C. FUNERAL DIRECTOR

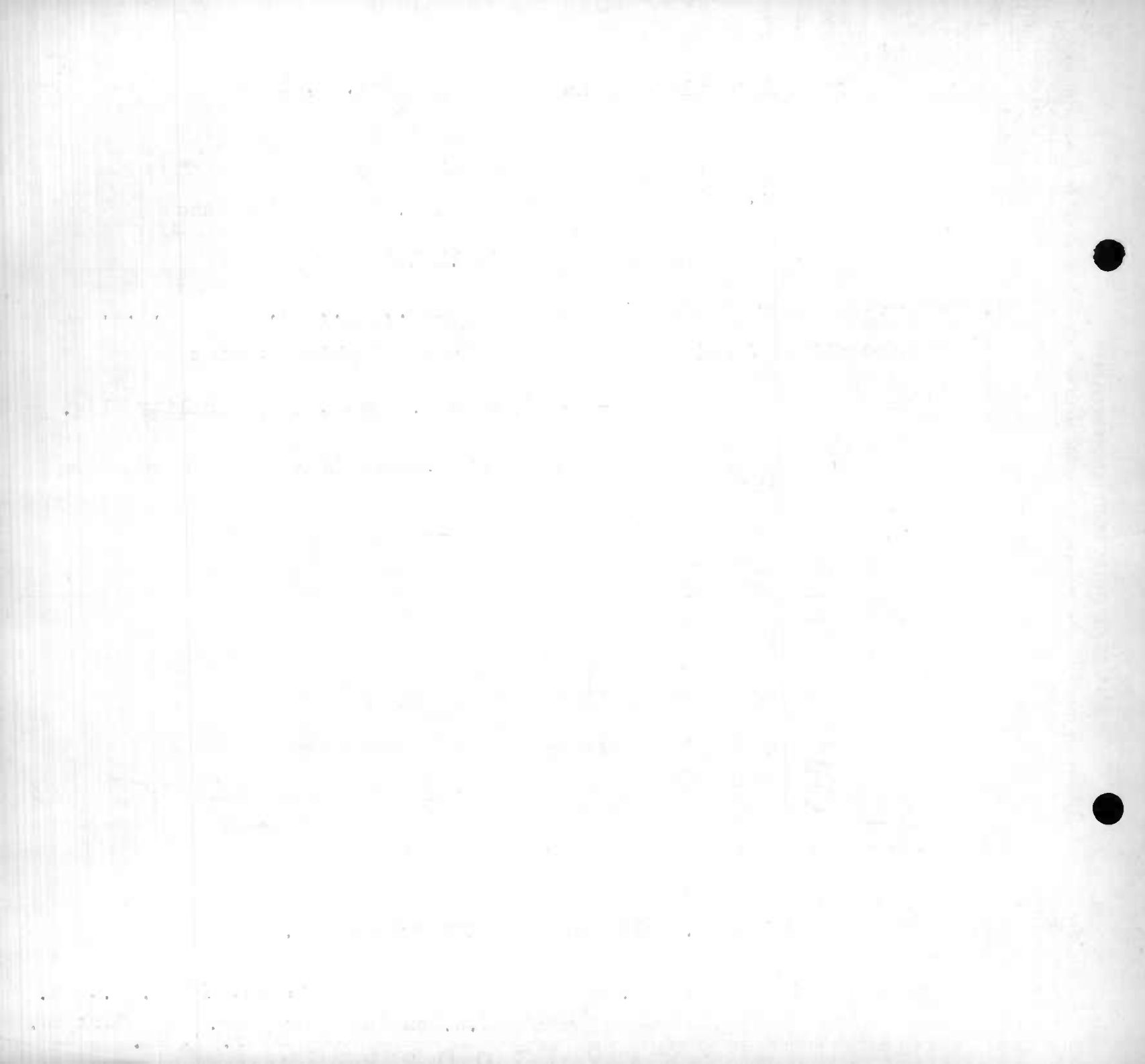
Wm. Cook-Brooks, Inc. 1217 St. Paul Street  
Baltimore, Maryland



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10070</u>	
BIRTH NO. <u>66 10070</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Michael Oswald Jenkins</u>		2. DATE AND HOUR OF DEATH <u>Oct. 5, 1966</u> <u>10<sup>45</sup> A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>Wynnwood Towers</u> <u>100 W. Cold Spring Lane</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>100 W. Cold Spring Lane</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10/11/1880</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Stock Broker</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard Hillen Jenkins</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Josephine Jenkins</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-22-6473</u>		17. INFORMANT ADDRESS <u>John M. Jones, 1403 Fidelity Bldg.</u>			
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Arteriosclerotic Cardio-Vascular disease</u> DUE TO (B) _____ DUE TO (C) _____			
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 2</u> 19 <u>62</u> to <u>Oct 5</u> 19 <u>66</u> , that (I) <del>was</del> lost saw the deceased alive on <u>at 3</u> 19 <u>66</u> and that in (my) <del>was</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <u>W. G. Helfrich</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10-6-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William G. Helfrich</u>		23D. ADDRESS <u>5006 Roland Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/8/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. John's</u>	
24D. LOCATION (City, town, or county) (State) <u>Long Green, Balto. Co., Md.</u>		25A. DATE REC'D IN HEALTH DEPT. <u>OCT 6 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>			

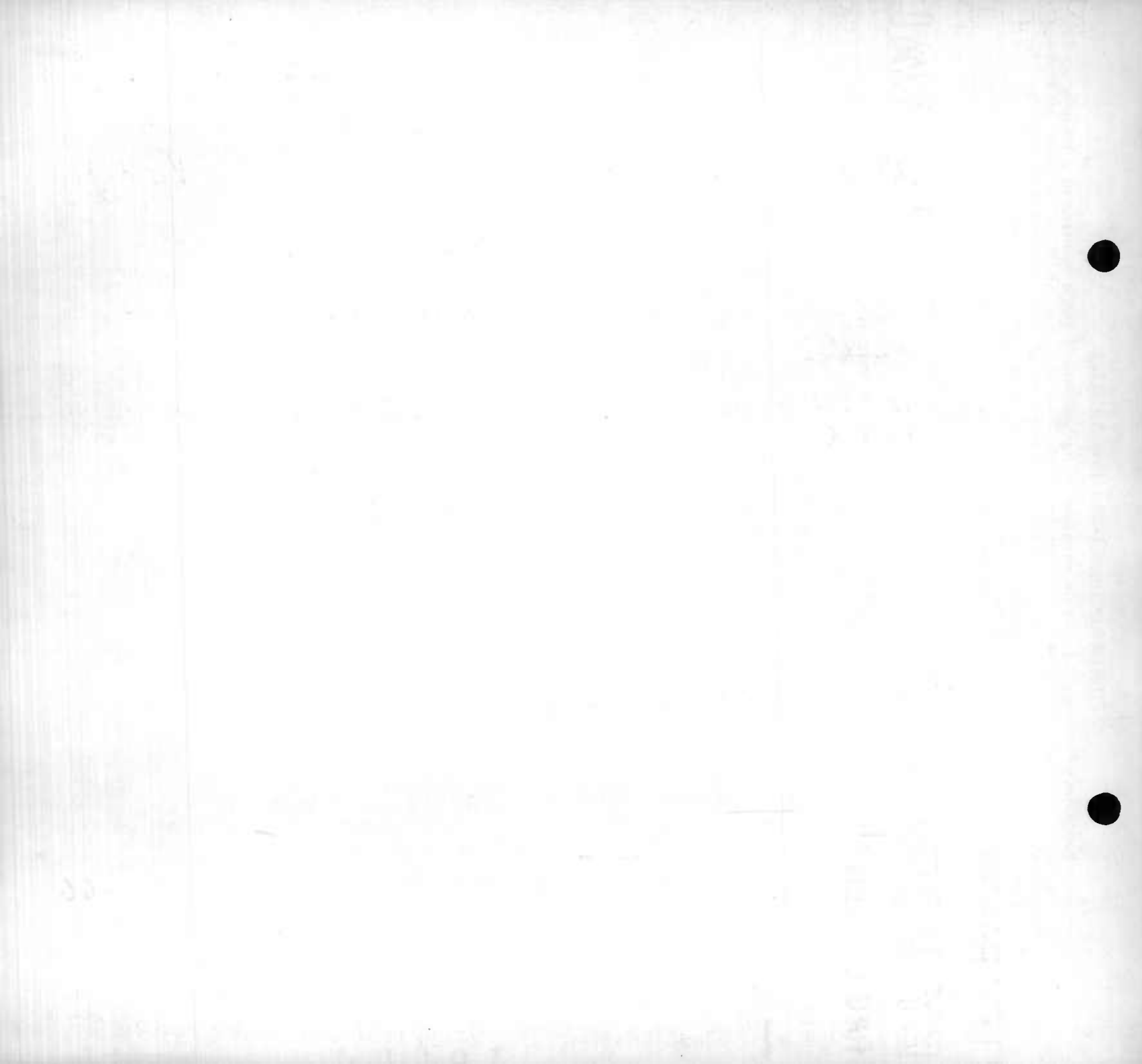




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10071		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10071	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Arthur Rawlings</i>		2. DATE AND HOUR OF DEATH 10-4-66 8.30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY NEW JERSEY		5. SEX MALE	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN (If outside city limits, write RURAL and give township) MARLTON		6. RACE WHITE	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 25 BANCROFT ROAD		7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER - NATIONAL GARAGE N.J.		B. DATE OF BIRTH 10-6-29		9. AGE (In years lost birthday) 36	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LINCOLN PARK, MICH.		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME NEWTON RAWLINGS		14. MOTHER'S MAIDEN NAME KATHRYN MCKANNA		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES PEACETIME		16. SOCIAL SECURITY NO. 267305875		17. INFORMANT R.C. ALEKS F.H. 1324 SOUTHFIELD RD LINCOLN PARK MICH.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) 157 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH (A) DUE TO aspiration of vomitus		INTERVAL BETWEEN ONSET AND DEATH 15 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CA of pneumonia & metastasis					
19A. DATE OF OPERATION 8/9/22		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED jaundice		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-1-66 to 10-4-66, that (I) (we) last saw the deceased alive on 10-4-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter Smithwick		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-4-66	
23C. PHYSICIAN'S NAME (Type) WALTER SMITHWICK		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-8-66		24C. NAME of CEMETERY or CREMATORY OUR LADY OF HOPE	
24D. LOCATION (City, town, or county) (State) WAYNE County MICH.		25A. DATE REC'D BY HEALTH DEPT. OCT 6 1966			
25B. NAME OF REGISTRAR J. E. F. J. F.		25C. FUNERAL DIRECTOR HENRY W. JENKINS & SONS Co. 4905 YORK RD BALTO. MD.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10072</u>
BIRTH NO. <u>66 10072</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Roy E. Buck</u>		
2. DATE AND HOUR OF DEATH <u>Oct. 5, 1966</u> <u>4<sup>23</sup></u> <u>P.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 Maryland General Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
		D. STREET ADDRESS (If rural, give location) <u>5819 The Alameda</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10/5/1922</u>	9. AGE (In years lost birthday) <u>44</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lieut. Fire Dept.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>	11. BIRTHPLACE (State or foreign country) <u>Eastville, Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Roy E. Buck</u>		14. MOTHER'S MAIDEN NAME <u>Mapps</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII &amp; Korean</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Ruth K. Buck</u> ADDRESS (Same)	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion Sudden</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Artery Disease 3 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>		
<b>II</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>October 1963</u> to <u>October 1966</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>October 4, 1966</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>do</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <u>Charles F. O'Donnell</u>		23B. DATE SIGNED <u>10/6/66</u>		
23C. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		23D. ADDRESS <u>7501 York Road</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/10/1966</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1966</u>	25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>		

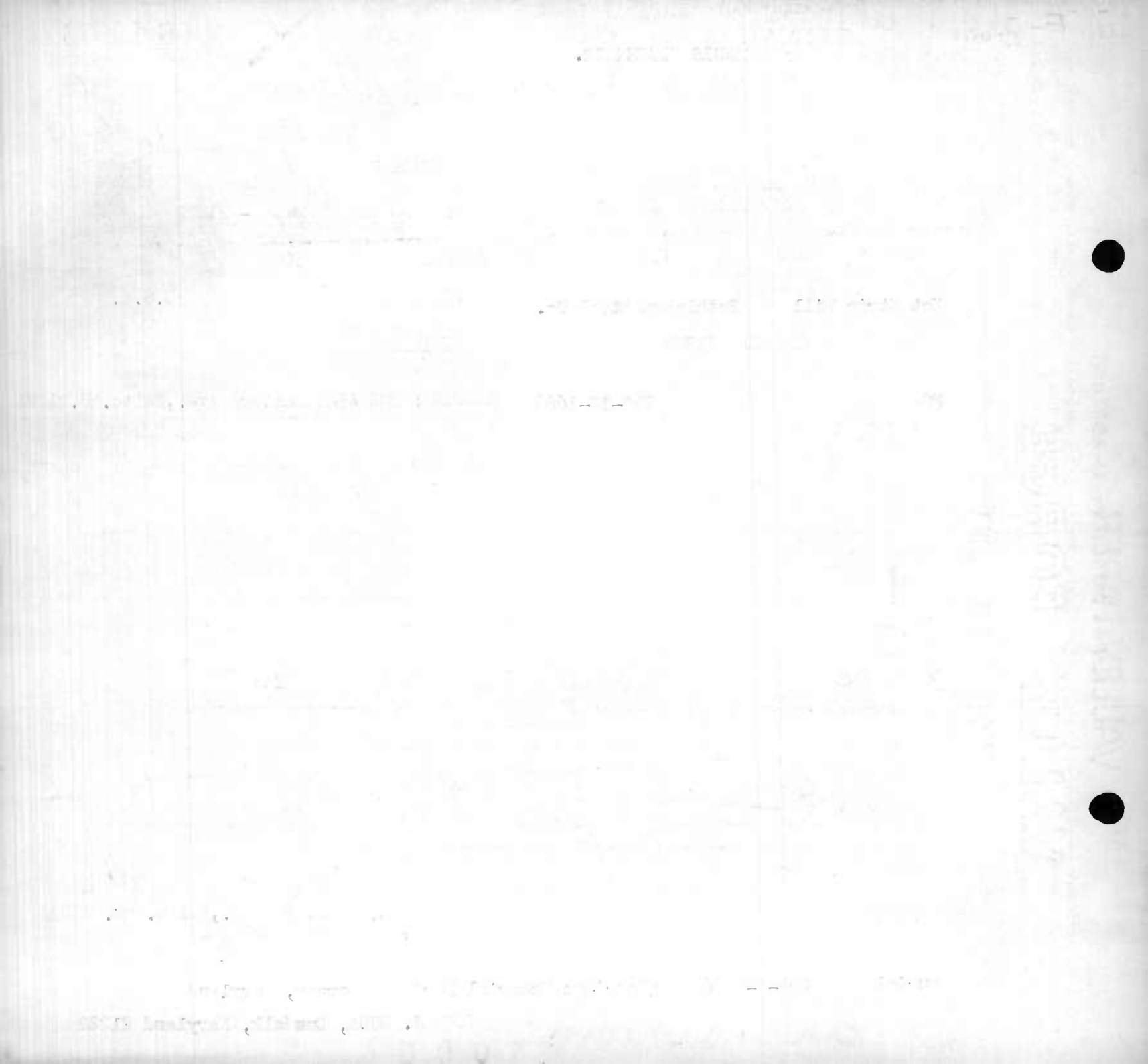


47-70-74  
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 10073</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 10073</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FRANCIS FISHER SR.</b> <i>Francis Fisher</i>		2. DATE AND HOUR OF DEATH <b>10/3/66</b> <b>1 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>DUNDALK</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND 21224</b>		D. STREET ADDRESS (If rural, give location) <b>8228 LONG POINT ROAD - 21222</b>		53-00	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4/3/16</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hot Strip Mill</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARD FISHER</b>		14. MOTHER'S MAIDEN NAME <b>LUCILLE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>230-12-3666</b>		17. INFORMANT <b>RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>199.2 I</b> <b>Metastatic carcinoma</b> <b>primary site unknown</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3 9-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diagnosis poss. BIR tumor</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from <b>9/14/66</b> to <b>10/3/66</b> and that (2) we last saw the deceased alive on <b>10/3/66</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Franklin G. Strauss</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Franklin G. Strauss</b>		23D. ADDRESS <b>4940 Eastern Ave., Balto. Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct-6-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>	
24D. LOCATION <b>Dorsey, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>	



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66 10074

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 64-01384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10074

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>STEVEN M. SAFRANEK</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>October 3, 1966</b> <b>8:37 A.M.</b>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>35 Church Home Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore - Dundalk</b> D. STREET ADDRESS (If rural, give location) <b>907 Elton Avenue</b>									
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>		8. DATE OF BIRTH <b>Jan. 18, 1964</b>	9. AGE (In years last birthday) <b>2</b>	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Albert Safranek, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Unsoeld</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (Father) ADDRESS <b>Albert Safranek 907 Elton Ave. Balto. Md.</b>									
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Suppurative Laryngitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION <b>2</b>								19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>October 3, 1966</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>													
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>Oct. 6-1966</b>		23C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		24C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>									

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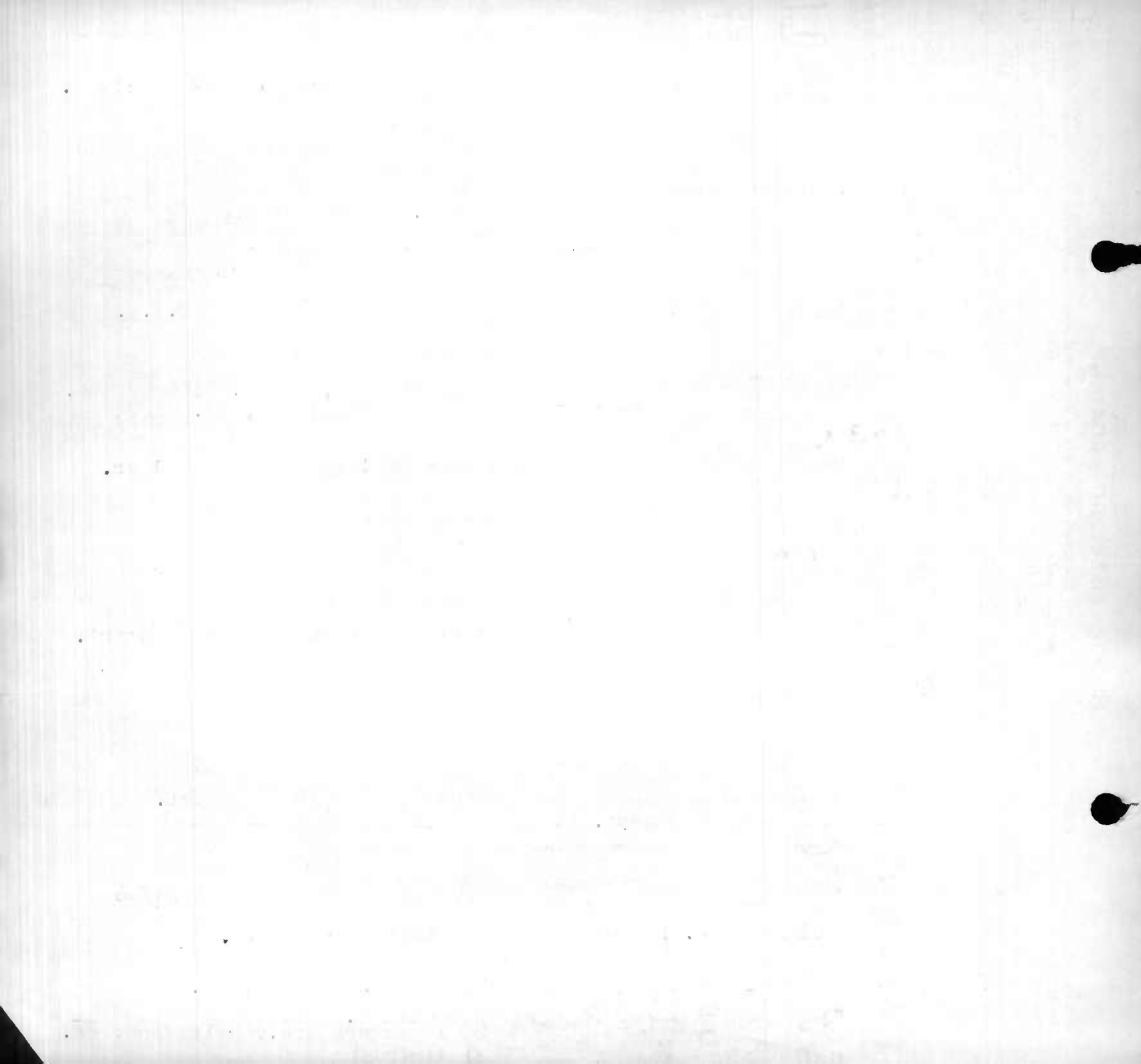
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# FUNERAL DIRECTOR: IMPORTANT

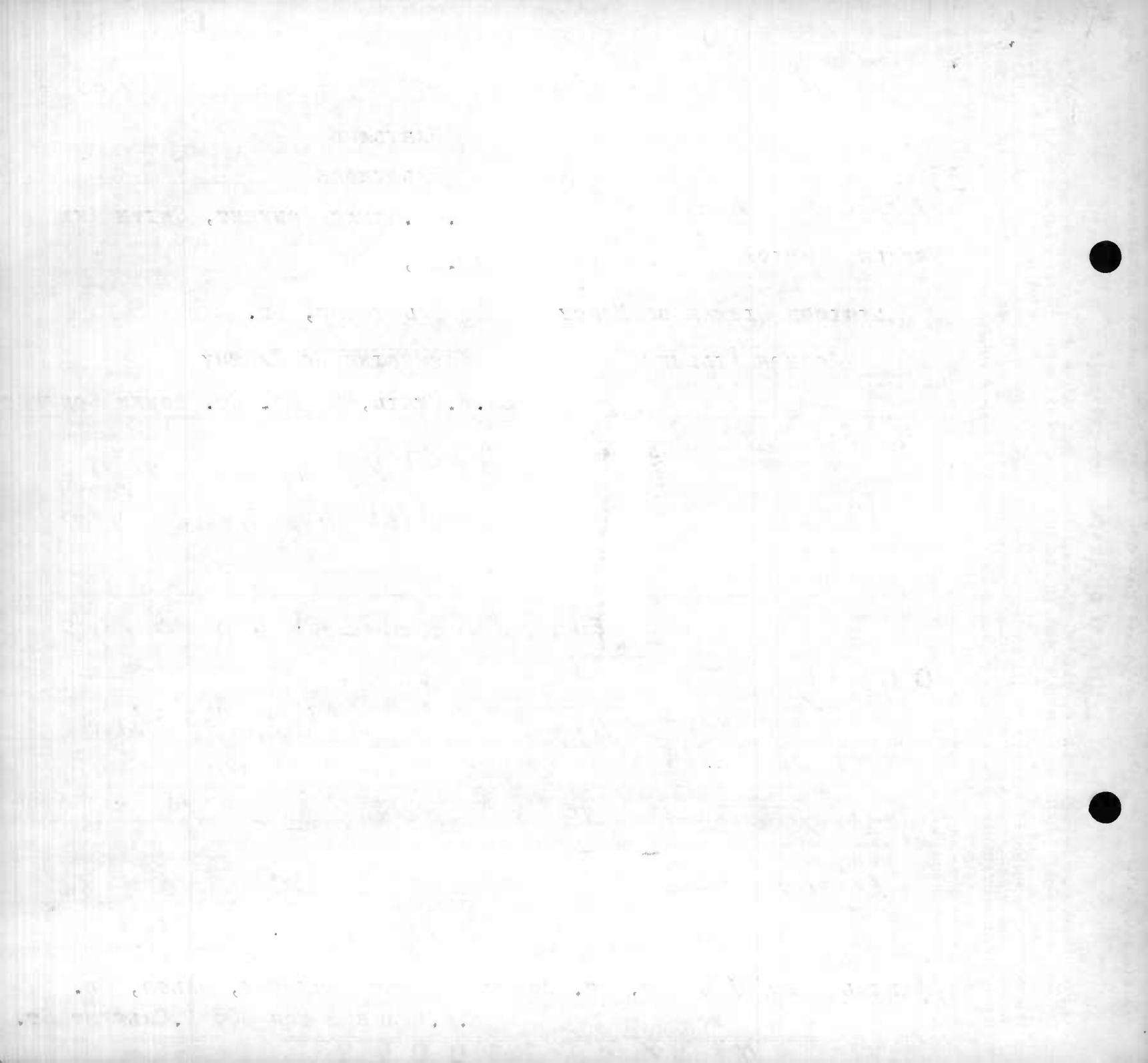
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10075</b>	
BIRTH NO. <b>66 10075</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>JOSEPH WILLIAM HEID</b>			<b>October 3, 1966   1:30 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>600 S. Ellwood Avenue</b>			A. STATE <b>Maryland</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>600 S. Ellwood Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>4/27/07</b>	9. AGE (In years lost birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hardware store</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Gustav</b>			14. MOTHER'S MAIDEN NAME <b>Jennie Bertlein</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-16-6189</b>	17. INFORMANT <b>William Heid, 600 S. Ellwood Ave. Baltimore, Md. 21224</b>		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Carcinoma of lung</b> DUE TO		<b>1 yr.</b>
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Pulmonary Emphysema</b>		<b>6 yrs.</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March 19 49</b> to <b>Oct. 19 66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept. 26 19 66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Clarence W. LeDoux</b> M.D.				23B. DATE SIGNED <b>10/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Clarence W. LeDoux</b> M.D.				23D. ADDRESS <b>3023 Eastern Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/6/66</b>	24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Sisk</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b> <b>3021 Eastern Ave., Baltimore, Md.</b>	



Medical Examiner, Dr. Singgale, called and body was released to Mercy Hosp.  
P-3615  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10076		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10076	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SR. M. Petronilla (Frances Kilduff)		2. DATE AND HOUR OF DEATH 10-3-66 9:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital		A. STATE MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) MT. ST. AGNES CONVENT, SMITH AVE			
5. SEX FEMALE		6. RACE WHITE			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH 1888		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS SISTER OF MERCY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOSEPH KILDUFF		14. MOTHER'S MAIDEN NAME KATHERINE MC CARTHY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS SR. M. CYRIL, RSM Mt. St. Agnes Convent	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, osthenio, etc. It means the disease or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO ASCVD (B) DUE TO Essential Hypertension (C)		INTERVAL BETWEEN ONSET AND DEATH many years many years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.		Fracture of Left Hip		5 days	
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) yes		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Mt. St. Agnes Mt. Washington, Md.	
21D. TIME OF INJURY (APPROX.) 9 28 66 9 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell out of wheel chair	
22. I certify that (I) (this hospital) attended the deceased from 9-28-66 to 10-3-66, that (I) (we) lost saw the deceased alive on 10-3-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Werner Beck		23B. DATE SIGNED 10-3-66	
23C. PHYSICIAN'S NAME (Type) Werner Beck		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/6/66		24C. NAME OF CEMETERY or CREMATORY MT. ST. AGNES CONVENT CEMETERY, BALTO, MD.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966		25B. NAME OF REGISTRAR H.W. MEARS & SON 805 N. CALVERT ST.	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10077				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 66 10077			
1. NAME OF DECEASED (Type or Print) <b>LaRue Robinette</b>				2. DATE AND HOUR OF DEATH <b>Oct. 4, 1966</b>   <b>2:52 P. M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 Sinai Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5248 Linden Heights Ave.</b>							
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 9, 1911</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Ellicott City, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Benjamin H. Sommers</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Mills</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-07-8742</b>		17. INFORMANT <b>Mr. John H. Robinette, 5248 Linden Heights Av.</b>				ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I Acute Myocardial Infarction</b>				CAUSE OF DEATH (A) DUE TO <b>A. S. H. D.</b> (B) DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chronic Bronchitis</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>4/25/57</b> 19 to <b>10/4/66</b> 19, that (I) <del>(we)</del> last saw the deceased alive on <b>10/4/66</b> 19 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.											
23A. SIGNATURE <b>Julius C. Gluck</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>10/6/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Julius C. Gluck, M.D.</b>				23D. ADDRESS <b>5356 Reisterstown Road.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Good Shepherd Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>N. Rogers Ave. Ellicott City, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		25B. NAME OF REGISTRAR <b>Edna E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>B. Vernon Lemmon, 4611 Park Heights Ave.</b>							

Great West Coast Refinery

A 240

Chronic Potassium

10/14/10

10/22/10

10/14/10

10/14/10

John C. Black



66 10078

BALTIMORE CITY HEALTH DEPARTMENT

66 10078

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Eston Cherry

2. DATE AND HOUR PRONOUNCED DEAD

10/4/66 7:37 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore  
D. STREET ADDRESS (If rural, give location)  
2801 Rockrose Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 3, 1913

9. AGE (In years  
(last birthday))

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sandy Cherry

14. MOTHER'S MAIDEN NAME

Ella Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

237-32-9805

17. INFORMANT

ADDRESS

Jeanette Cherry 2801 Rockrose Road

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

O

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/4/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-8-66

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

Arbutus Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 7 1966

R. G. E. Farkas

George Kelson 1348 N. Calhoun Street

WALTER B. BOYD

1-520

66 10079

BALTIMORE CITY HEALTH DEPARTMENT

66 10079

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Francis W. Jones

2. DATE AND HOUR PRONOUNCED DEAD

10/4/66 8:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 763 W. Saratoga St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

763 W. Saratoga St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-30-06

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Jones

14. MOTHER'S MAIDEN NAME

Mary Mason

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

213-14-9901

17. INFORMANT

ADDRESS

Mary V. Jones 763 Saratoga Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/4/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-7-66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

ADDRESS

George Kelson 1348 N. Calhoun Street

OCT 7 1966 1966 0003 0002

VALLEY FORGE

1  
B-346

66 10080

BALTIMORE CITY HEALTH DEPARTMENT

66 10080

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Agnes Butler

2. DATE AND HOUR PRONOUNCED DEAD

10/3/66

7:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 928 N. Woodyear St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

928 N. Woodyear St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

7-26-84

9. AGE (In years  
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Romulus Garner

14. MOTHER'S MAIDEN NAME

Mary Willard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Florence Griffin 100 Smallwood St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive cardio-  
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/4/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-8-66

23C. NAME OF CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 7 1966

R. E. E. F. F. F.

George Kelson 1348 Calhoun St.

WALLIEY FOMGE  
HAD CONTENT

7

1954



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10081		CERTIFICATE OF DEATH		Registered No. 66 10081		
1. NAME OF DECEASED (Type or Print) <i>Morris Jamie</i>				2. DATE AND HOUR OF DEATH <i>Oct. 5, 1966</i> <i>9<sup>29</sup> A.M.</i>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>36 Franklin Square Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>20-01 342 N. Fulton Ave.</i>						
5. SEX <i>F.</i>	6. RACE <i>C.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>6-16-1895</i>		9. AGE (In years last birthday) <i>71 yrs.</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Griff Duncan</i>				14. MOTHER'S MAIDEN NAME <i>Margaret</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Hospital chart.</i>				ADDRESS	
18. <i>540.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>MASSIVE GASTRIC BLEEDING</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>GASTRIC ULCER, LARGE</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>9-21-66</i> 1966 to <i>10-5</i> 1966, that (I) <u>(we)</u> last saw the deceased alive on <i>Oct. 5</i> 1966 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.										
23A. SIGNATURE <i>H. B. Lee</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Oct. 5 1966</i>				
23C. PHYSICIAN'S NAME (Type) <i>Ki Bum Wee</i>				23D. ADDRESS <i>Franklin Square Hospital</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-8-66</i>		24C. NAME of CEMETERY or CREMATORY <i>MT. ARBURN CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>				
25A. DATE RECEIVED BY HEALTH DEPT. <i>OCT 7 1966</i>				25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>GEORGE KELSON</i>				
				ADDRESS <i>1348 CALHOUN ST.</i>						



9-15-1882 2142

Missive (Gibson) 4-18-1882  
Gibson (Missive) 4-18-1882

George 12-18-1882 to Missive (Gibson) 4-18-1882  
Gibson (Missive) 4-18-1882

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

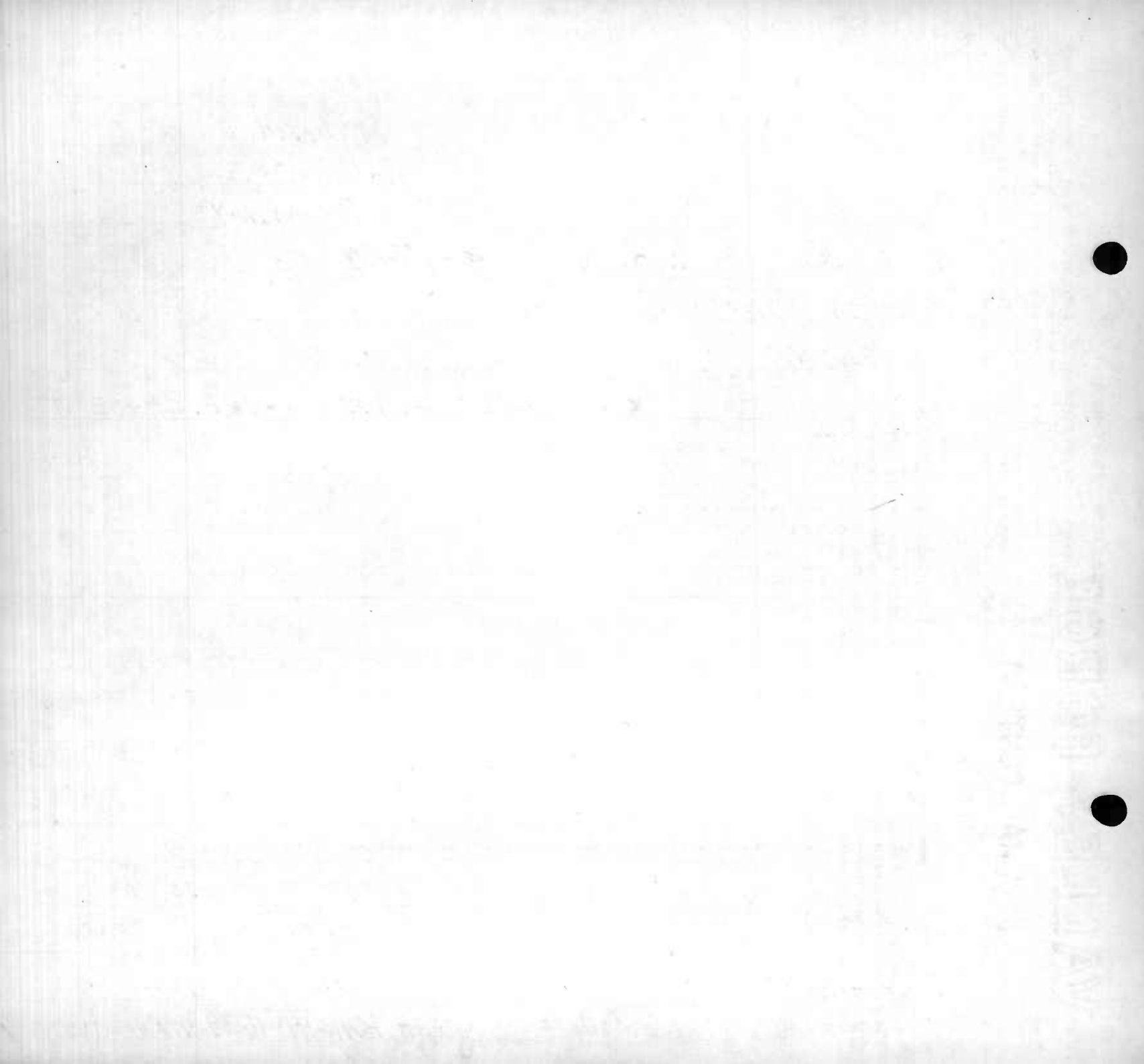
<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>Registered No. <b>66 10082</b></p>	
<p>BIRTH NO. <b>66 10082</b></p> <p>M.E. CASE NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <b>MORGAN, MARGARET J</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>10/04/66 3:55 P.M.</b></p>		<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND 21229</b> B. COUNTY <b>Balt. Co.</b></p>		<p>5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b></p>	
<p>8. DATE OF BIRTH <b>2-28-82</b> 9. AGE (In years last birthday) <b>84</b></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U S A</b></p>	
<p>13. FATHER'S NAME <b>PETER (DEC'D)</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>SUSAN HEALY (DEC'D)</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p>16. SOCIAL SECURITY NO. <b>219-10-0202</b></p>	
<p>17. INFORMANT <b>Susan Morgan - 790 Charring Cross Rd</b></p>		<p>ADDRESS <b>HOSPITAL SLIP - ST. AGNES HOSPITAL</b></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>450.01</b></p>		<p>CAUSE OF DEATH (A) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO <b>DIRECT CAUSE OF DEATH:</b> (B) <b>ACUTE PULMONARY EDEMA</b> DUE TO (C) _____</p>	
<p>19. DATE OF OPERATION _____</p>		<p>20. AUTOPSY? (Yes or No) _____</p>	
<p>21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	
<p>23. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____</p>		<p>24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>	
<p>25. I certify that (X) (this hospital) attended the deceased from <b>OCTOBER 4, 1966</b> to <b>OCTOBER 4, 1966</b>, that (X) (we) last saw the deceased alive on <b>OCTOBER 4, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.</p>		<p>26. SIGNATURE <b>Juan T. Cabrera</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>	
<p>27. PHYSICIAN'S NAME (Type) <b>JUAN T. CABRERA</b></p>		<p>28. DATE SIGNED <b>10/04/66</b></p>	
<p>29. BURIAL - CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>30. DATE <b>10-7-66</b></p>	
<p>31. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b></p>		<p>32. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b></p>	
<p>33. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b></p>		<p>34. NAME OF REGISTRAR <b>Witzke F.D.</b></p>	
<p>35. FUNERAL DIRECTOR <b>Witzke F.D.</b></p>		<p>ADDRESS <b>4101 Edmondson Ave.</b></p>	

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY FOR  
GENERAL AFFAIRS  
MAIL ROOM  
MAIL STOP 100  
WASHINGTON, D.C. 20250

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10083		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10083	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert F. Foley		2. DATE AND HOUR OF DEATH 10-5-66			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 1735 N. Broadway FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1735 N. BROADWAY			
5. SEX MALE	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-1-7-1883	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KITCHEN HELPER SHEARTON CORP.		10B. KIND OF BUSINESS OR INDUSTRY Miss.		11. BIRTHPLACE (State or foreign country) Miss.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 326155463		17. INFORMANT LILLIAN DEAN 2406 E. CHASE ST	
18. 421.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema		CAUSE OF DEATH (A) DUE TO Mitral Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 12 Hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension		(B) DUE TO (C) DUE TO		5 years ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-20-1961 to 10-5-1966, that (I) (we) last saw the deceased alive on 10-1-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eugene H. Owens M.D.		23B. DATE SIGNED 10-6-66		23C. PHYSICIAN'S NAME (Type) Eugene H. Owens M.D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-10-66		24C. NAME OF CEMETERY or CREMATORY CHICAGO ILL.	
25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966		25B. NAME OF REGISTRAR Robert E. Foley M.D.		25C. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY	



BALTIMORE CITY HEALTH DEPARTMENT

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ELIZABETH C. VACEK</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 5, 1966 7:25 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>44 Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore #14 27-44</b> D. STREET ADDRESS (If rural, give location) <b>3214 Hamilton Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec. 29, 1890.</b>
10A. USUAL OCCUPATION (Give kind of work done during rest of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>75</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Muhlmickel</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-54-9065</b>	
17. INFORMANT <b>Mrs. Catherine Moulden</b>		ADDRESS <b>(Same)</b>	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  DUE TO <b>(A) Arteriosclerotic Cardiovascular Disease</b>  DUE TO <b>(B) _____</b>  DUE TO <b>(C) _____</b>  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  DUE TO <b>(A) _____</b>  DUE TO <b>(B) _____</b>  DUE TO <b>(C) _____</b>			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>10/8/66.</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		24B. NAME OF REGISTRAR <b>R. E. 2. F. ...</b>	
24C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. 14, Md.</b>		ADDRESS	

VALLEY FOLIOLE

PROS CONTINUT

17

Immunis

Wider

Nov. 27, 1950.

Immunis

Catharine

Michael Hubmickel

Nov. 27, 1950.

(200)

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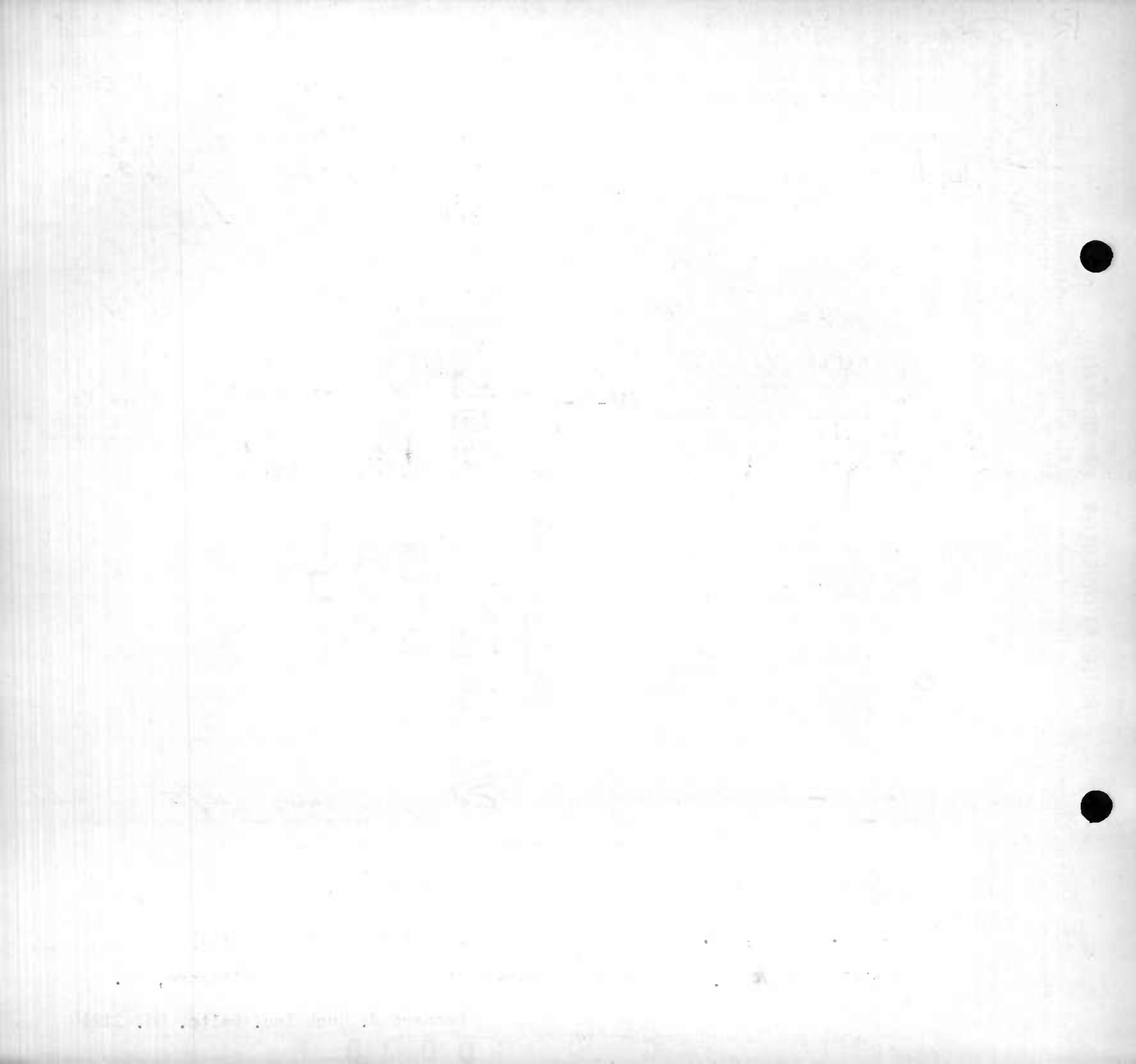
Immunis



# FUNERAL DIRECTOR: IMPORTANT

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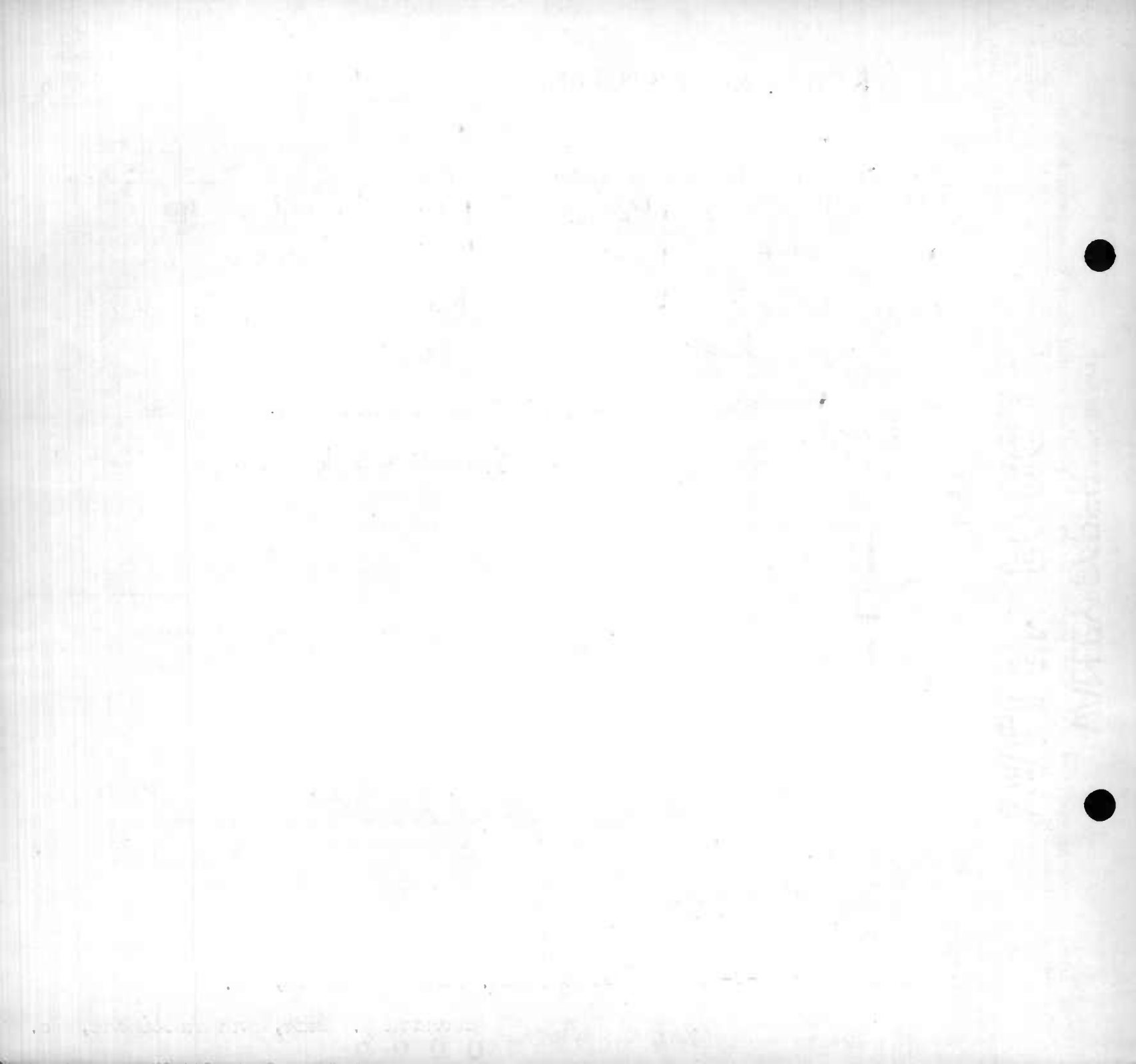
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10085	
66 10085				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mabel Teresa Reinig</i>	
2. DATE AND HOUR OF DEATH <i>Oct. 5, 1966 11:25 A.M.</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Joppatown</i>			
D. STREET ADDRESS (If rural, give location) <i>716 Ferguson Rd.</i>		5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>			
8. DATE OF BIRTH <i>4/25/89</i> 9. AGE (In years last birthday) <i>77</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Richard Madden</i>		14. MOTHER'S MAIDEN NAME <i>Kathryn King</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-07-1705D</i>		17. INFORMANT <i>Mrs. Elora Woods</i> ADDRESS <i>Same</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Generalized ASCVD</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Bronchopneumonia</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>9/16</i> 19 <i>66</i> to <i>10/5</i> 19 <i>66</i> , that (I) <del>was</del> last saw the deceased alive on <i>10/5</i> 19 <i>66</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <i>Nat E. Watson, Jr.</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>10/5/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Nat E. Watson, Jr.</i> M.D.				23D. ADDRESS <i>The Union Memorial Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/10/66.</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fagley</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>	
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10086	
BIRTH NO. 66 10086		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 10086	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>KENT, Mr. BENJAMIN G.</b>		2. DATE AND HOUR OF DEATH <b>10/6/66 3:15 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balt. Co.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home &amp; Hospital</b> <b>100 N. Broadway, Baltimore, Md. 21231</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>1700 Weyburn Ave.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11-8-06</b>	9. AGE (In years last birthday) <b>59 yrs</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engr - Belts Steel</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Belts Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Kent</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hall</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213079072</b>		17. INFORMANT <b>Mrs Margaret Kent</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>330X I</b>		CAUSE OF DEATH (A) <b>Subarachnoid Hemorrhage</b> (B) <b>10-4-66</b> (C) <b>10-6-66</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10-4-66</b> <b>10-6-66</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Acute Pericardial Myocardial Infarction</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-4-66</b> to <b>10-6-66</b> , that (I) (we) last saw the deceased alive on <b>10-6-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-6-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. A. E. Subong, Jr.</b>		23D. ADDRESS <b>Church Home &amp; Hosp.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10-8-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc Baltimore, Md.</b>	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10087</u>	
BIRTH NO. <u>66 10087</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>John Wall</u>		2. DATE AND HOUR OF DEATH <u>10.4.66</u> <u>1</u> <u>P.</u> <u>M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Little Srs. of The Poor</u> <u>1200 VALLEY ST.</u> <u>Baltimore md. 21202</u>		A. STATE <u>MD.</u> B. COUNTY <u>10-01</u>			
5. SEX <u>Male</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED <u>WIDOWED</u> <u>DIVORCED</u> (Specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		8. DATE OF BIRTH <u>1.2.1883</u>	
13. FATHER'S NAME <u>Matthew Wall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen McKinley</u>		9. AGE (In years last birthday) <u>83</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-543395</u>		17. INFORMANT <u>Little Sisters of The Poor</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardiac failure</u> DUE TO (B) <u>Arteriosclerotic disease</u> DUE TO (C) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>Oct 3</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Justin Kudirka</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>10.5.66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Justin Kudirka</u>		23D. ADDRESS M.D. <u>2151 Wilkens Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Oct 6/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cathedral Cm. Baltimore</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 1966</u>			
25B. NAME OF REGISTRAR <u>Philip Herwig</u>		25C. FUNERAL DIRECTOR <u>2024 Orleans St</u>			

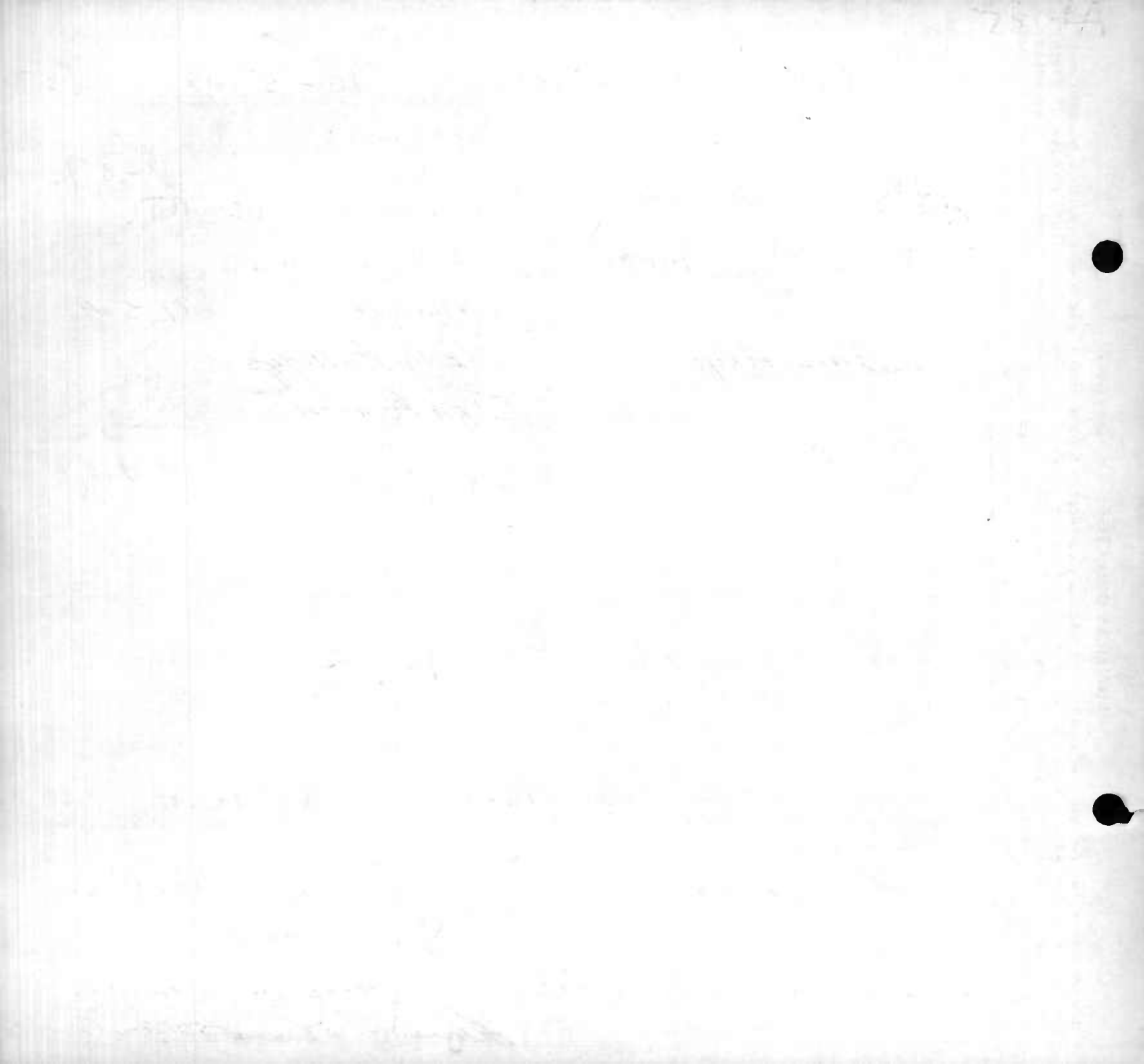


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10088		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10088	
M.E. CASE NO.		CERTIFICATE OF DEATH		3:00 P.M.	
1. NAME OF DECEASED (Type or Print) Ashton, Anna Mae		2. DATE AND HOUR OF DEATH 10-5-66			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		A. STATE DELAWARE			
(If not in hospital or institution, give street address or location)		B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) CAMDEN V-07			
		D. STREET ADDRESS (If rural, give location) Box 802 STAR RT.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-30-03	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME Ellic Argo		14. MOTHER'S MAIDEN NAME Sally Billings		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT IRA ASHTON	
18. 590 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Acute renal failure etiology undetermined clinically (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-1-1966 to 10-5-1966, that (I) (we) lost saw the deceased alive on 10-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gordon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-5-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Sinai Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/5/66		24C. NAME of CEMETERY or CREMATORY BARRETT'S CHAPEL	
24D. LOCATION (City, town, or county) (State) FREDERICK, DELAWARE		25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR William E. Jackson 8521 Loch Raven Blvd.			

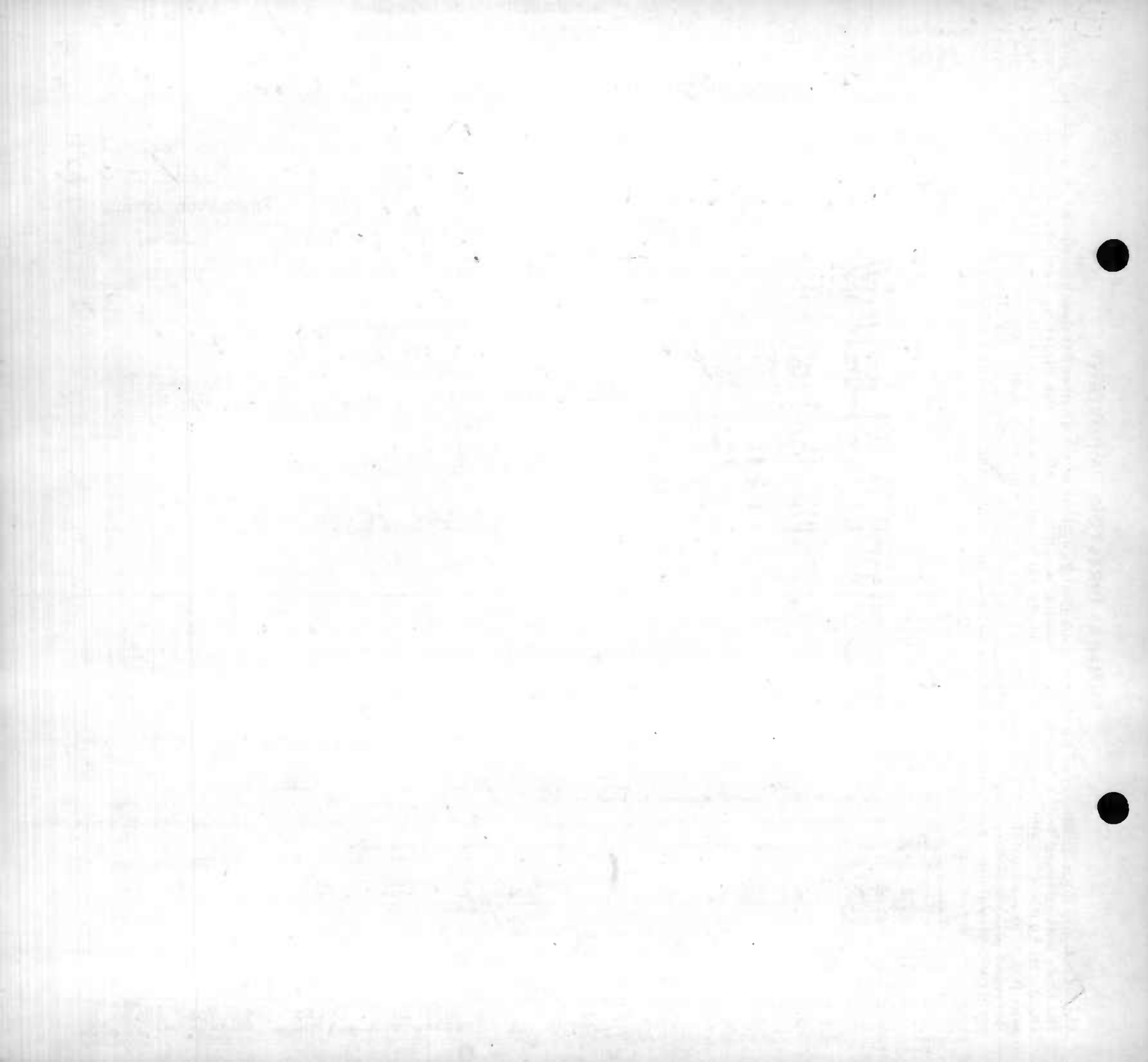




# FUNERAL DIRECTOR: IMPORTANT

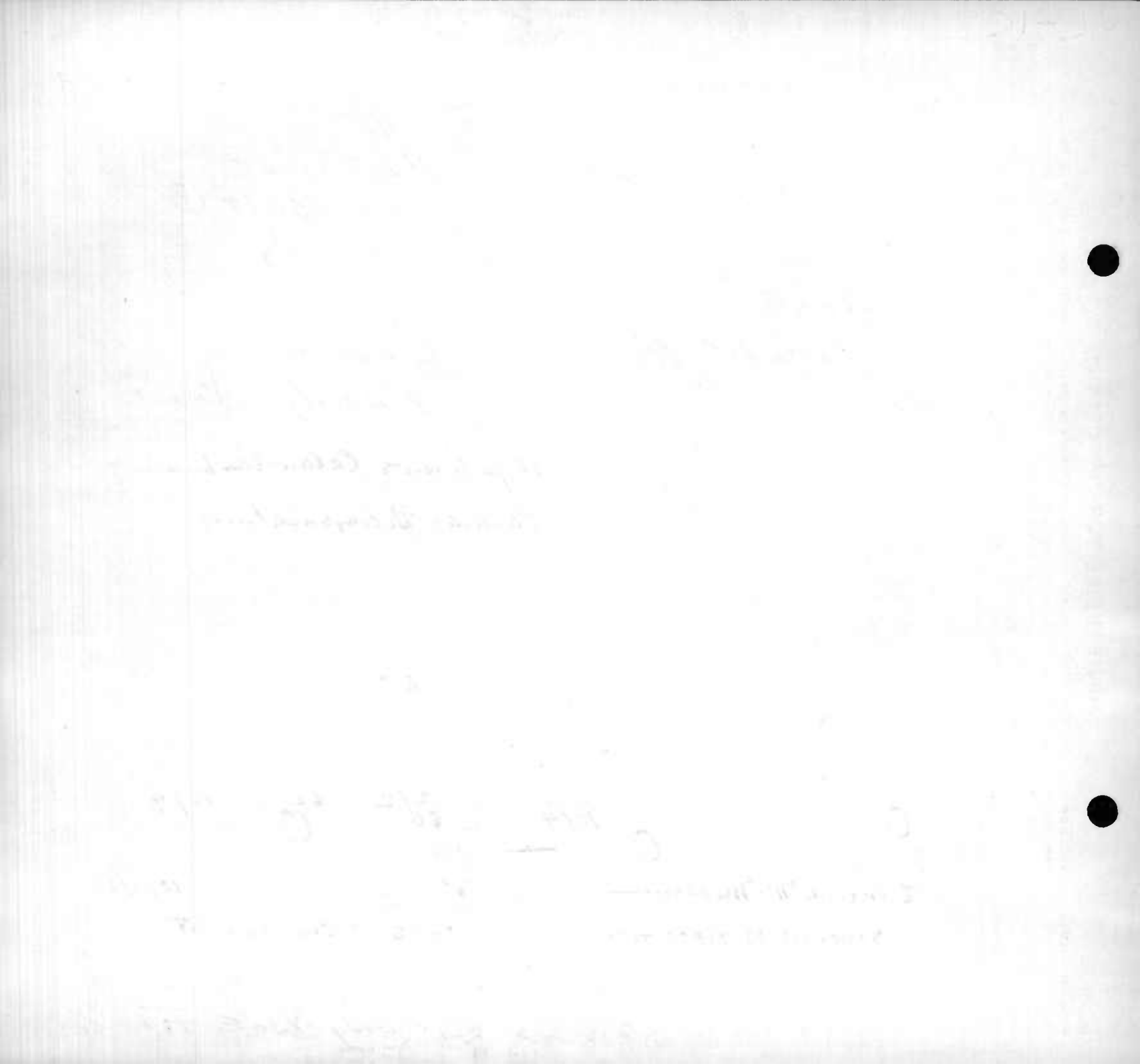
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		66 10089	
BIRTH NO. 66 10089		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 66 10089	
1. NAME OF DECEASED (Type or Print) <i>Pluma Bowman</i>		2. DATE AND HOUR OF DEATH <i>10/5/66</i> <i>9:40</i> @ M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 University Hospital</i>		A. STATE <i>Ohio</i> B. COUNTY <i>Chesapeake</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>✓-32</i> D. STREET ADDRESS (If rural, give location) <i>Rt # 1 Powhatan Avenue</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2-9-93</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>--</i>	9. AGE (In years last birthday) <i>73</i>
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Wright</i>		14. MOTHER'S MAIDEN NAME <i>Emma Jossel</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>272-48-0233T</i>	
17. INFORMANT <i>Hilda F. Wherley</i>		ADDRESS <i>7932 Kavanagh Rd Balto. Md. 21222</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Cardiac Infarct</i> (B) <i>Generalized arteriosclerosis</i> (C) <i>Cholecystectomy</i> INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Atrial fibrillation</i>			
21A. DATE OF OPERATION <i>0</i>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 5</i> 19 <i>66</i> to <i>Oct 5</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Samuel Legum</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10-5-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>SAMUEL LEGUM M.D.</i>		23D. ADDRESS <i>1261 E. North Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/10/66</i>	24C. NAME OF CEMETERY or CREMATORY <i>Miller Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Miller, Ohio</i>
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	
25C. FUNERAL DIRECTOR <i>Eugenia K. Seitz</i>		ADDRESS <i>5209 York Rd. Balto. Md. 21212</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10090	
66 10090				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
FRANCES L. EVANIS		10-4-66		1:05 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE		
1504 BELT ST			MD.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			1504 BELT ST		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
F	W	W.	7-31-93	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE				Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
FRANK BURKE			Isabelle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Family - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
443X I			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Hypertensive Cardio-Vascular Disease		
			(B) Cardiac Decompensation		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 2/2 1962 to 10/4 1966, that (1) (we) last saw the deceased alive on 10/4 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Vincent M. Messina				10/4/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Vincent M. Messina		1403 S. Charles ST			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
B	10/7/66	NEMPLOW		Nemplova Rd	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 7 1966		Robert E. Fajana		1403 S. Charles	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 10091</b>	
66 10091		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		10/03/66 7:00 P.M.	
1. NAME OF DECEASED (Type or Print) <b>SMITH, FRANCES E.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> Caton and Wilkens Avenues BALTIMORE, MD. 21229		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>15 S. BEECHWOOD AVENUE</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-23-80</b>
9. AGE (In years lost, in day)		10. CITIZEN OF WHAT COUNTRY?	
<b>86</b>		<b>U S A</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<b>RETIRED</b>		<b>RHODE ISLAND</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
<b>NONE</b>		<b>U S A</b>	
13. FATHER'S NAME <b>CHARLES SMITH MERCHANT</b>		14. MOTHER'S MAIDEN NAME <b>MARY RHODES</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS <b>HOSPITAL SLIP - ST. AGNES HOSPITAL</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>782.44 IE902.0</b> <b>Fracture left hip</b>		CAUSE OF DEATH <b>Heart failure</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>19-21-1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture L hip</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>yes</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
21C. WHERE DID INJURY OCCUR? <b>15 S. Beechwood Ave.</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>9-15-1966</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell from bed.</b>	
22. I certify that (X) (this hospital) attended the deceased from <b>SEPTEMBER 15 1966</b> to <b>OCTOBER 3, 1966</b> that (X) (we) last saw the deceased alive on <b>OCTOBER 3, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Carl A. Matthey</b>		23B. DATE SIGNED <b>10/03/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARL A. MATTHEY</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL</b> <b>Caton and Wilkens Avenues</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/6/66</b>	24C. NAME of CEMETERY or CREMATORY <b>LOUDDON PARK</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>	25B. NAME OF REGISTRAR <b>P. E. E. Fasham</b>	25C. FUNERAL DIRECTOR <b>P. J. McPhail</b> <b>301 FREDERICK RD</b> <b>BALTO 21228</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10092</u>	
BIRTH NO. <u>66 10092</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <u>Elizabeth IRENE MEADOWS</u>		2. DATE AND HOUR OF DEATH <u>10/4/66 11:30 AM</u> M.	
(Type or Print)					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Harford Co.</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Monkton</u>			
<u>33</u>		D. STREET ADDRESS (If rural, give location) <u>62-00</u>			
		<u>----Jarrettsville Pike</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4/4/13</u>	9. AGE (In years (last birthday)) <u>53</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Scott</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>James Meadows</u> ADDRESS <u>Jarrettsville Pike Monkton, Maryland</u>	
18. <u>296X I.</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>Cardiac arrest</u> DUE TO (B) <u>Purpura fulminans</u> DUE TO (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/18</u> 19 <u>66</u> to <u>10/4</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kenneth L. Brigham</u>				23B. DATE SIGNED <u>10-4-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>KENNETH L. BRIGHAM</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL <u>Burial</u>		24B. DATE <u>10/8/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Chestnut Grove A.M.E.</u>	
				24D. LOCATION (City, town, or county) (State) <u>Rocks, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>OCT 7 1966</u>		25B. NAME OF REGISTRAR <u>Charles E. Kurtz</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Jarrettsville, Md.</u>	

1948-1949

1948-1949

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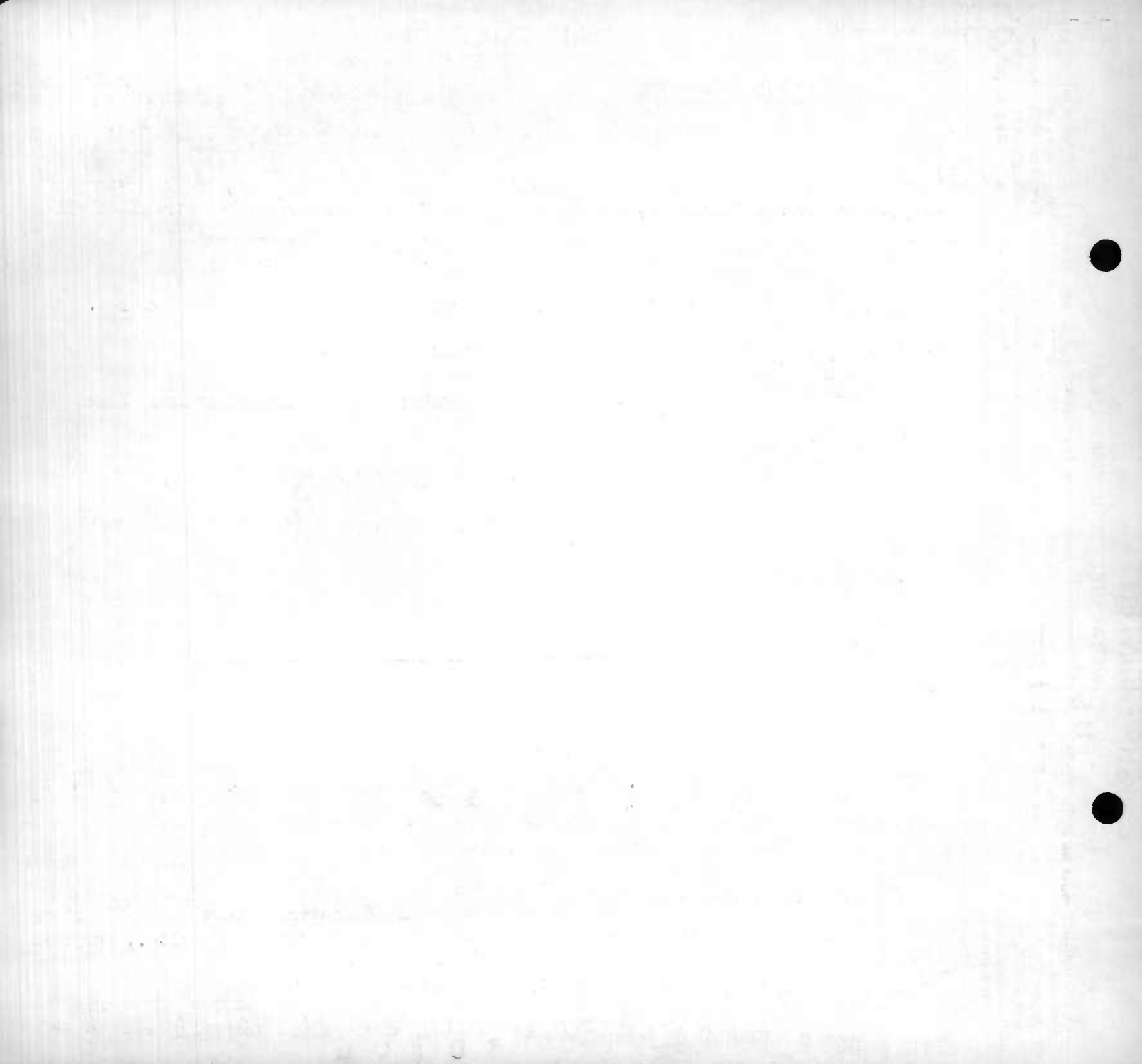
1948-1949

1948-1949

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10093		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10093	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Harry M. Younger		2. DATE AND HOUR OF DEATH 10/5/66 9:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hosp. 21224 4940 Eastern Avenue Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. 6-04 D. STREET ADDRESS (If rural, give location) 418 N. Washington Street 21231			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/25/01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY City of Baltimore		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Younger		14. MOTHER'S MAIDEN NAME Romans, Katie B.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-03-100		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 163X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cardiorespiratory arrest (B) DUE TO carcinoma of the lung (C) —		INTERVAL BETWEEN ONSET AND DEATH 5 min 8 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/30 19 66 to 10/5 19 66, that (I) (we) last saw the deceased alive on 10/5 19 66 and that (my) (our) apinian death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. P. Wilkinson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/5/66	
23C. PHYSICIAN'S NAME (Type) C. P. Wilkinson		23D. ADDRESS 4940 Eastern Avenue 21224 Baltimore City Hosp Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/8/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery Baltimore Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Felix E. Gruch		ADDRESS 1211 Chesaco Ave.	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CONRAD LONG

2. DATE AND HOUR PRONOUNCED DEAD

October 4, 1966 5:41 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

730 S. Robinson Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Feb. 7 - 1894

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John

14. MOTHER'S MAIDEN NAME

Baum

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Jesse Long

ADDRESS

730 S. Robinson St.

18. 422.1 002.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Pulmonary Tuberculosis (by history)

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-8-66

23C. NAME of CEMETERY or CREMATORY

Mt. Carmel

23D. LOCATION

Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

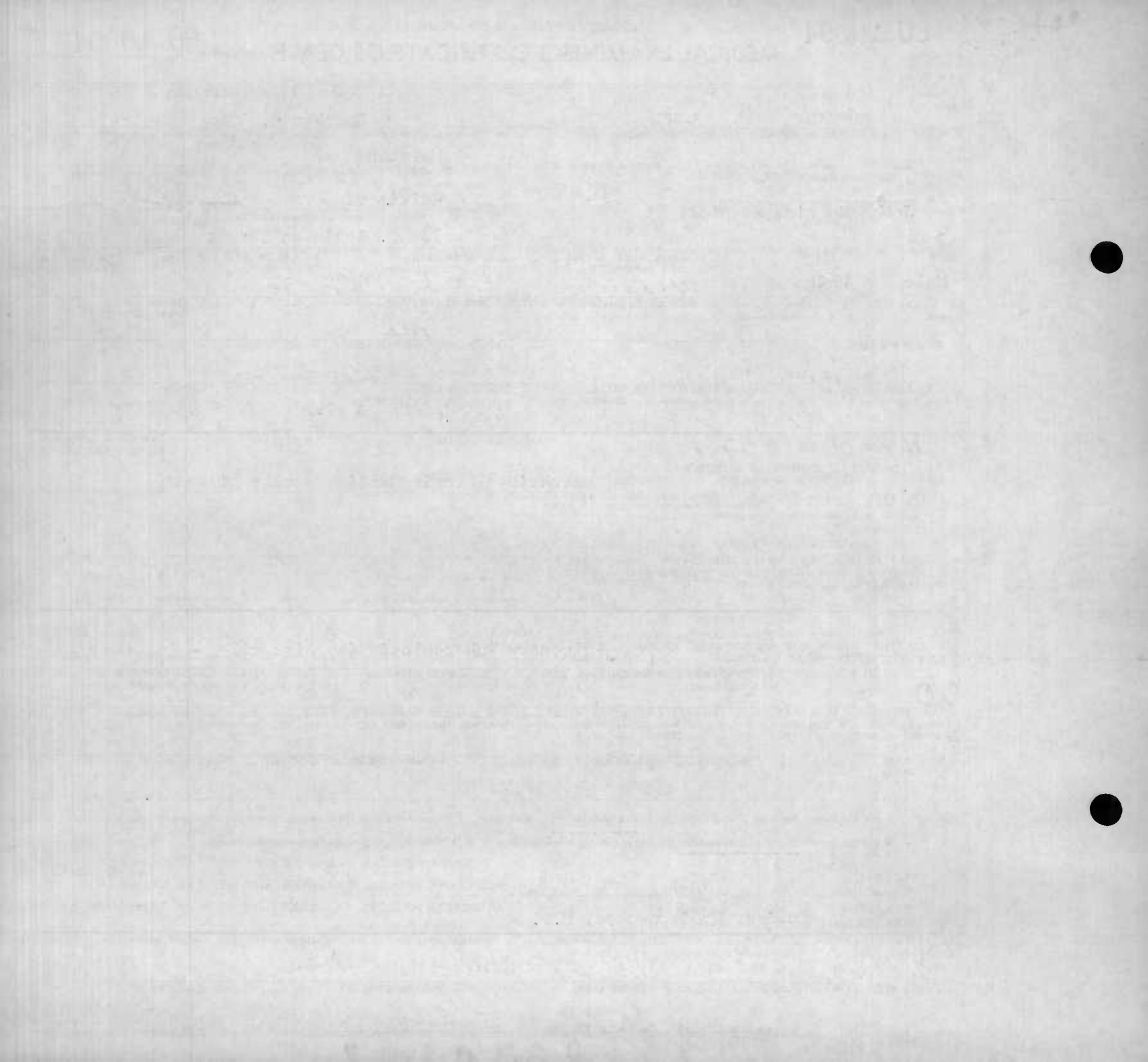
Robert E. Taylor

24C. FUNERAL DIRECTOR

Thelma A. Hoffman

ADDRESS

3218  
Hudson St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 24pt;">66 10095</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 24pt;">66 10095</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 18pt;">Vincent Powell</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 18pt;">10-5-1966</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 18pt;">Baltimore City Hospital</span>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 18pt;">Maryland</span> B. COUNTY <span style="font-size: 18pt;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 18pt;">26-05</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 18pt;">6716 Fait Avenue</span>		
5. SEX <span style="font-size: 18pt;">Male</span>	6. RACE <span style="font-size: 18pt;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 18pt;">Married</span>	8. DATE OF BIRTH <span style="font-size: 18pt;">I-28-1911</span>	9. AGE (In years last birthday) <span style="font-size: 18pt;">55</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 18pt;">Driver</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 18pt;">Printers Finishers</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 18pt;">Balto., Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 18pt;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 18pt;">Walter Przysylowski</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 18pt;">Lena Ludwiski</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 18pt;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 18pt;">215-03-2346</span>			17. INFORMANT <span style="font-size: 18pt;">Viola Powell - 6716 Fait Ave. #2</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 18pt;">Myocardial Infarction</span>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 18pt;">Coronary Artery Thrombosis</span>			(B) DUE TO <span style="font-size: 18pt;">Arteriosclerosis</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 18pt;">Rheumatic Heart Disease</span>					
19A. DATE OF OPERATION <span style="font-size: 18pt;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 18pt;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <span style="font-size: 18pt;">11-13-1965</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 18pt;">11/13</span> 19 <span style="font-size: 18pt;">65</span> to <span style="font-size: 18pt;">9/22</span> 19 <span style="font-size: 18pt;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 18pt;">9/22</span> 19 <span style="font-size: 18pt;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 18pt;">PAUL G. KOUKOULAS</span>				23B. DATE SIGNED <span style="font-size: 18pt;">10/5/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 18pt;">Paul G. Koukoulas</span>				23D. ADDRESS <span style="font-size: 18pt;">6511 O'Donnell St #24 Balto</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 18pt;">Burial</span>		24B. DATE <span style="font-size: 18pt;">10/8/66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 18pt;">Holy Rosary</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 18pt;">Balto., Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 18pt;">OCT 7 1966</span>			
25B. NAME OF REGISTRAR <span style="font-size: 18pt;">Robert E. Farley</span>		25C. FUNERAL DIRECTOR <span style="font-size: 18pt;">Halter Babrowski - 1005 Sunduck Ave. #24</span>			



1911

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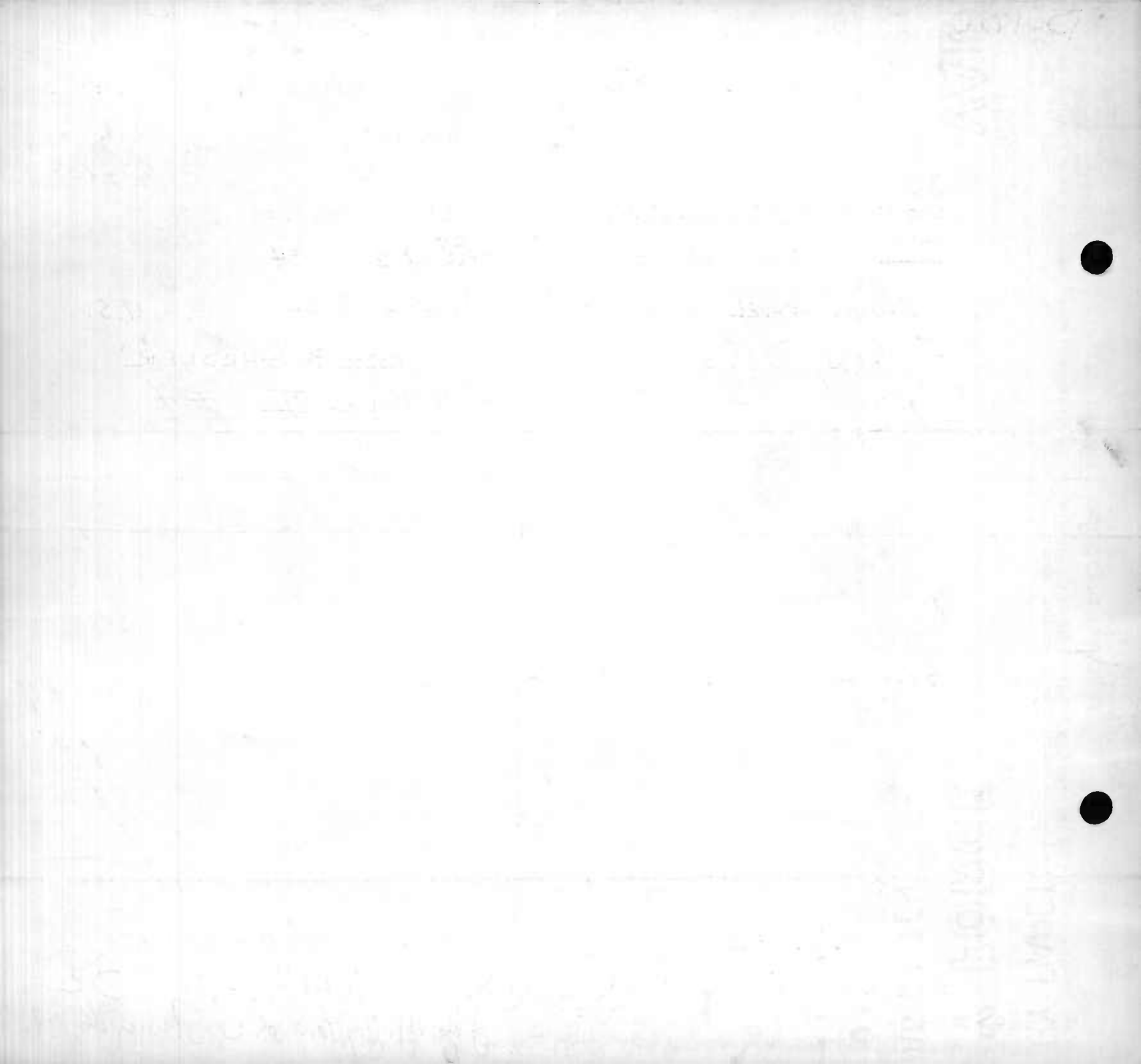
1929

121 56 14  
DOVE, JOHN M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

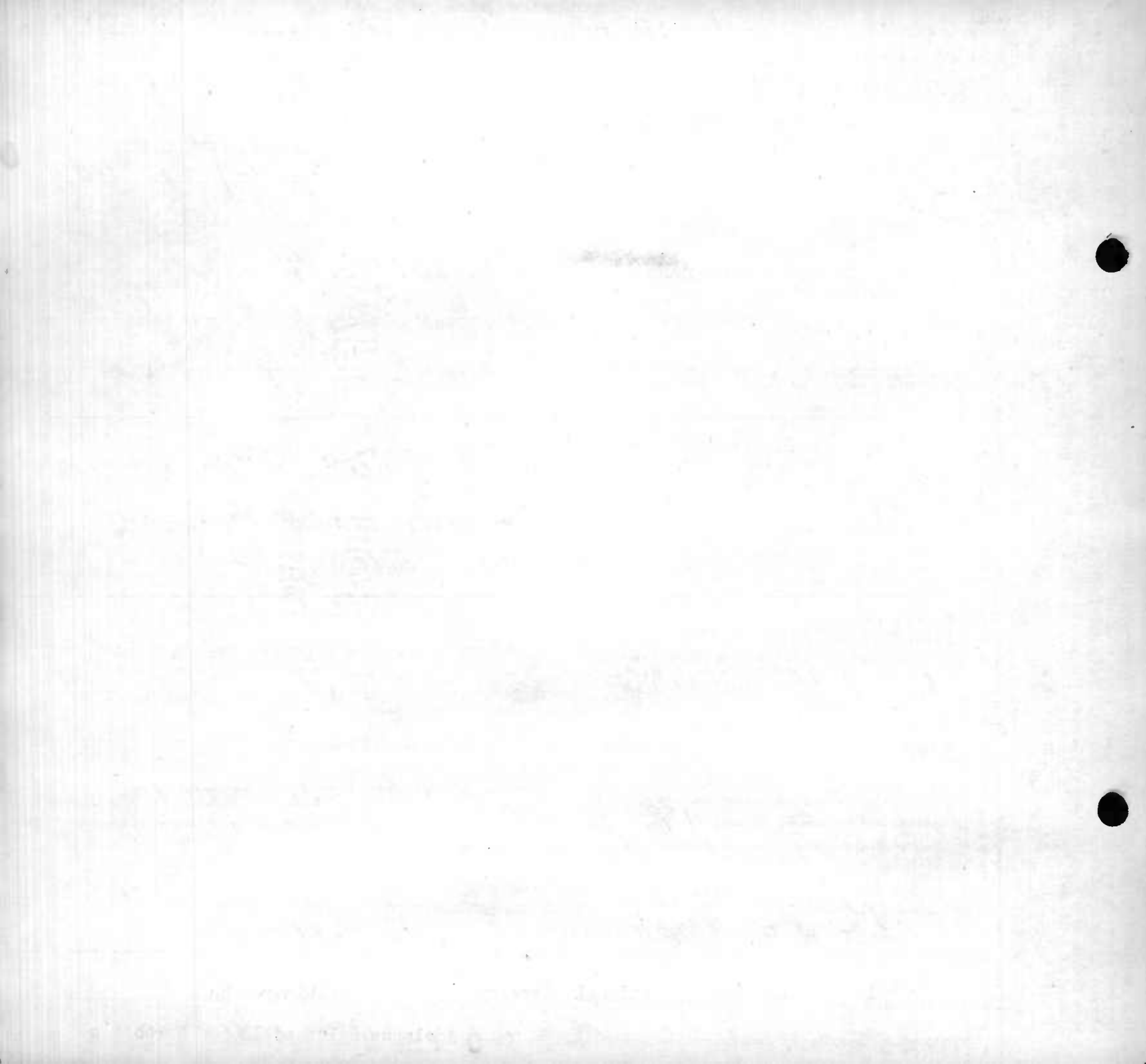
BIRTH NO. 66 10096		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10096	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John M. Dove Jr		2. DATE AND HOUR OF DEATH October 4, 1966 10:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A.A. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annapolis 52-10 D. STREET ADDRESS (If rural, give location) 910 Primrose Road			
5. SEX Male White	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 27/28/1912	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAND & GRAVEL		10B. KIND OF BUSINESS OR INDUSTRY CONCRETE		11. BIRTHPLACE (State or foreign country) WASH. D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME J. MAURY DOVE			
14. MOTHER'S MAIDEN NAME Helen B. GARDNER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO -			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS J.M. DOVE III #4			
18. 581.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Lame's Curvature DUE TO (B) Bleeding esophageal varices DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 10-1-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED bleeding - GI tract		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 10-4-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. J. Gill		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-4-66	
23C. PHYSICIAN'S NAME (Type) A. J. Gill		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-6-66		24C. NAME OF CEMETERY or CREMATORY Rock Creek	
24D. LOCATION (City, town, or county) (State) Washington D.C.		25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966			
25B. NAME OF REGISTRAR John M. Taylor		25C. FUNERAL DIRECTOR ADDRESS John M. Taylor & Sons Annapolis, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10097		CERTIFICATE OF DEATH		Registered No. 66 10097	
1. NAME OF DECEASED (Type or Print) <b>ROBINSON, WILLIE MAE</b>				2. DATE AND HOUR OF DEATH <b>1:50 PM 10-1-66</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>UNIVERSITY HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE, Md</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>17-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE CITY - 1- Md</b> D. STREET ADDRESS (If rural, give location) <b>411 - N. PINE ST.</b>					
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>1-14-21</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>			16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>?</b>				
18. <b>606X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>GRAM NEGATIVE SEPSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SHOCK -</b> <b>INFECTED BLADDER DIVERTICULUM</b> <b>SMALL BOWEL OBST. -</b> <b>COLOSTOMY -</b>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <b>8-26 -&gt; 10-1-66</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>9-14-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BLADDER DIVERTICULUM</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (a) (this hospital) attended the deceased from <b>8-26</b> 19 <b>66</b> to <b>10-1</b> 19 <b>66</b> , that (b) (we) last saw the deceased alive <b>1:50 PM 10-1-66</b> and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Robert W. Bentley</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-1-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>ROBERT W. BENTLEY</b>		23D. ADDRESS <b>UNIV. HOSPITAL -</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/6/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25D. ADDRESS <b>1206 W North Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10098				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10098	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Nannie Belle Johns</i>				2. DATE AND HOUR OF DEATH <i>5:20 p.m. Oct 31 1966</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, give RURAL and give township) <i>Baltimore 9-08</i> D. STREET ADDRESS (If rural, give location) <i>730 East 20th Street</i>			
5. SEX <i>F</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>? (unknown)</i>	9. AGE (In years lost birthday) <i>? + 90</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>Susan Brown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>220-03-3740</i>		17. INFORMANT <i>Mrs. Margaret Staples</i>			ADDRESS <i>730 E. 20th Street Baltimore Md 21218</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Lanunc's Cirrhosis &amp; Esophageal varices &amp; Ascites</i>				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>September 27, 1966</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>open liver biopsy</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>August 22</i> 19 <i>66</i> to <i>Oct 3</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Oct 3</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J.D. Gardner</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10-3-1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. J. D. Gardner</i>				23D. ADDRESS <i>The Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/8/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>			
				ADDRESS <i>1206 W North Ave</i>			

James's Christian & Pictorial  
Review



K 400

66 10099

BALTIMORE CITY HEALTH DEPARTMENT

66 10099

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Sammy J.

KELLY

2. DATE AND HOUR PRONOUNCED DEAD

October 4, 1966

10:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

709 North Edgewood Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Oct. 13, 1929

9. AGE (In years  
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cement finisher

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Camden S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Sam Kelly

14. MOTHER'S MAIDEN NAME

Loise Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

847-36-2539

17. INFORMANT

ADDRESS

Barbara Kelly 709 N. Edgewood St.

18. E903.5

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Cranio-cerebral Injuries

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Sidewalk in front of 709 N. Edgewood St.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
10 3 '66 ?

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/8/66

23C. NAME OF CEMETERY or CREMATORY

974 Calvary Cem. Balto. Md.

23D. LOCATION

319 N. School St.

24A. DATE REC'D BY HEALTH DEPT.

OCT 7 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. School St.

ADDRESS

WATKINS

General Manager  
S. J. Kelly

No.

WATKINS

3201  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10100		CERTIFICATE OF DEATH		Registered No. 66 10100	
1. NAME OF DECEASED (Type or Print) <i>Stanski, Ida N.</i>				2. DATE AND HOUR OF DEATH <i>Oct. 6, 1966 2:08 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 - Church Home &amp; Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>USA 2-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>207 S. Wolfe St.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>9/5/1894</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Factory worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>NOVAK Ignatious Novak</i>		14. MOTHER'S MAIDEN NAME <i>KOSZAK Ida Kozak</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-164189</i>		17. INFORMANT <i>Adams Stanski, 207 S. Wolfe St.</i>		ADDRESS			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>Pulmonary Edema</i> (B) DUE TO <i>Myocardial Infarction</i> (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 6 1966</i> to <i>Oct. 6 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct. 6 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Nonita Suarez</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Oct. 6/1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>Nonita Suarez</i>				23D. ADDRESS <i>Church Home &amp; Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-11-1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Gardens of Faith</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Lilly &amp; Zeiler Inc.</i>		ADDRESS <i>1901-07 Eastern Ave.</i>			

Baltimore  
Kosak

W  
Fackord weeks  
Mouak

213 HALL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10101		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10101	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ERNEST LITTLE</b>		2. DATE AND HOUR OF DEATH <b>OCT. 6, 1966 5:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE Hosp.</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>25-33</b>			
5. SEX <b>M</b>		6. RACE <b>COLORED</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	
8. DATE OF BIRTH <b>JUN 6, 1915</b>		9. AGE (In years lost birthday) <b>51</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>	
13. FATHER'S NAME <b>JACOB LITTLES</b>		14. MOTHER'S MAIDEN NAME <b>ADDIE COLEMAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NID</b>		16. SOCIAL SECURITY NO. <b>44-0000-8358</b>		17. INFORMANT <b>NIFE</b>	
18. <b>5-8-7-0</b>		CAUSE OF DEATH		ADDRESS <b>2442 HOLLINS FERRY RD. BALTIMORE, 20, M.D.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>INTRABDOMINAL HEMORRHAGE</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) <b>2° RUPTURED GASTRODUODENAL ARTERY</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>2° ACUTE PANCREATITIS</b>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>OCT. 5, 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HEPATOMA + LUNG OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 7 1966</b> to <b>OCT. 6 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT. 6 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hila Grossa R. Calizo</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>OCT. 6, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>HILA GROSSA R. CALIZO</b>		23D. ADDRESS <b>FRANKLIN SQUARE Hosp. BALTIMORE, 23</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		25D. ADDRESS <b>661 W. Barre St.</b>			

Interpretation of the  
2. Further data on the  
3. New findings



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 10102		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10102	
BIRTH NO. 66 10102		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CRAWFORD CALDWELL</u>		2. DATE AND HOUR OF DEATH <u>10/5/66</u> <u>11:55</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-06</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2662 Presbury Street</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>10/23/15</u>	9. AGE (In years last birthday) <u>50</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Robert Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Roberts</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Elizabeth Caldwell</u>	
				ADDRESS <u>2662 Presbury St.</u>	
18. <u>H16X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>0</u>		CAUSE OF DEATH (A) <u>Pneumatic Heart Disease 4 yrs</u> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/26/66</u> 19 <u>66</u> to <u>10/5/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/5/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sandra L. Zucker</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Sandra L. Zucker</u>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-8-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Martinez D. H. H.</u>	
				ADDRESS <u>1701 Laurens St.</u>	



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1000 Broadway Street  
New York City  
N.Y.



Printed 10-8-66 by J. J. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT 3				66 10103		66 10103	
BIRTH NO. 66 10103				CERTIFICATE OF DEATH		Registered No. _____	
1. NAME OF DECEASED (Type or Print) <b>HENRY DESPER</b>				2. DATE AND HOUR OF DEATH <b>10-4-66 8 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-10</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4103 Barrington Road</b>			
5. SEX <b>M.</b>	6. RACE <b>N.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6-22-1909</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Charlottesville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Horace Desper</b>			14. MOTHER'S MAIDEN NAME <b>Mozella Desper</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-01-8260</b>		17. INFORMANT <b>Mrs. Esther Desper</b>		ADDRESS <b>4103 Barrington Rd</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Essential Hypertension</b> <b>At Sided Hemiplegia</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs -</b> <b>2 weeks -</b> <b>2 weeks -</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-19-66</b> to <b>10-4-66</b> , that (I) (we) last saw the deceased alive on <b>10-4-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Geo H Pendleton</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Geo H. PENDLETON</b>				23D. ADDRESS <b>1723 Druid Hill Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/10/66</b>	24C. NAME of CEMETERY or CREMATORY <b>BALTO. NAT'L CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		25B. NAME OF REGISTRAR <i>Edgar E. Farley</i>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>			
				ADDRESS <b>1701 Laurens St.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10104		CERTIFICATE OF DEATH		Registered No. 66 10104	
1. NAME OF DECEASED (Type or Print) <b>Frederick F. Kaufman</b>				2. DATE AND HOUR OF DEATH <b>October 5th. 1966</b> 7 <sup>25</sup> P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>5</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md.</b> D. STREET ADDRESS (If rural, give location) <b>606 N. Glover Street 5</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Apr. 26, 1905</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Howard Furniture Co. Baltimore d.</b>			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Michael Kaufman</b>			14. MOTHER'S MAIDEN NAME <b>--</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>--</b>			16. SOCIAL SECURITY NO. <b>213-09-8020</b>		17. INFORMANT <b>Margaret S. Kaufman, 606 N. Glover St. 5</b>				
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral Arteriosclerosis</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>was</del> <b>not</b> ) attended the deceased from <b>4/25 1966</b> to <b>Oct. 5 1966</b> , that (I) ( <del>was</del> <b>not</b> ) last saw the deceased alive on <b>Oct 5 1966</b> and that in (my) ( <del>my</del> <b>my</b> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> <b>not</b> ) view the body after death.									
23A. SIGNATURE <b>Louis Kline</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>								23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>L. F. Kline M.D.</b>								23D. ADDRESS <b>2623 E. Monument St. 5</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore d.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		25B. NAME OF REGISTRAR <b>Philip E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Philip Herwigson</b>		ADDRESS <b>2024 Orleans St.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10105		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10105	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type in Print) Kelly, George Roscoe		2. DATE AND HOUR OF DEATH 10/6/66 321 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles Gen Hosp.		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) # 21230 D. STREET ADDRESS (If rural, give location) 1273 Battery Ave. 24-03			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/10/1910	9. AGE (In years last birthday) 55 yrs.	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY Arrow Carton Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William E. Kelly deceased		14. MOTHER'S MAIDEN NAME Emma Daniels		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-5461		17. INFORMANT Patients' clerk ADDRESS	
18. I 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Bronchogenic carcinoma right upper and middle lobes (B) DUE TO with metastases (C) Arterio sclerotic heart disease years		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-26-1966 to 10-6-1966, that (I) (we) last saw the deceased alive on 10-6-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. W. Kohn / Michael M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10/6/66	
23C. PHYSICIAN'S NAME (Type) WALTER KOHN		23D. ADDRESS North Charles Gen. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 10, 1966		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery, Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.			

Kelly, George

Baltimore  
#21310

1523 Battery Ave.  
Baltimore

white married  
Arrow Carbon Co.

Baltimore

216-07-241



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10106		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10106	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs STELLA EdNA Compton		2. DATE AND HOUR OF DEATH Sept 29, 1966 11 30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		A. STATE Md. B. COUNTY Baltimore City			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-49			
		D. STREET ADDRESS (If rural, give location) #1 So. KRESSON ST.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/23/14	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homewife		10B. KIND OF BUSINESS OR INDUSTRY OWN Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME STEPHEN STREET		14. MOTHER'S MARRIED NAME SARAH WHITT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RALPH Compton Conowingo, Md.	
18. 6333X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) SEPTICEMIA DUE TO (B) Subphrenic / Subhepatic Abscess DUE TO (C) PNEUMONIA -		INTERVAL BETWEEN ONSET AND DEATH 5 poss. 5-9 days 9 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Vaginal Hysterectomy				9/15/66	
19A. DATE OF OPERATION 9/15/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Vaginal Hysterectomy		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from Sept 12, 1966 to Sept 29, 1966, that (I) last saw the deceased alive on Sept 29, 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Wm Gregory Bruna M.D.		23B. DATE SIGNED 9/29/66			
23C. PHYSICIAN'S NAME (Type) WILLIAM G. BRUNA M.D.		23D. ADDRESS Mercy Hosp. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-2-66		24C. NAME OF CEMETERY or CREMATORY CONOWINGO Baptist CONOWINGO	
24D. LOCATION (City, town, or county) (State) Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966		25B. NAME OF REGISTRAR Robert E. Farkner	
25C. FUNERAL DIRECTOR Richard L. Goodie		25D. ADDRESS Rising Sun			

Mr. Stella E. Conklin Sept 20, 1902

Md. Baltimore #1 St. James St.

F. W. Howard Sept 20, 1902  
Stephan Street

Sept 20, 1902  
Sept 20, 1902  
Sept 20, 1902

Sept 20, 1902  
Sept 20, 1902  
Sept 20, 1902

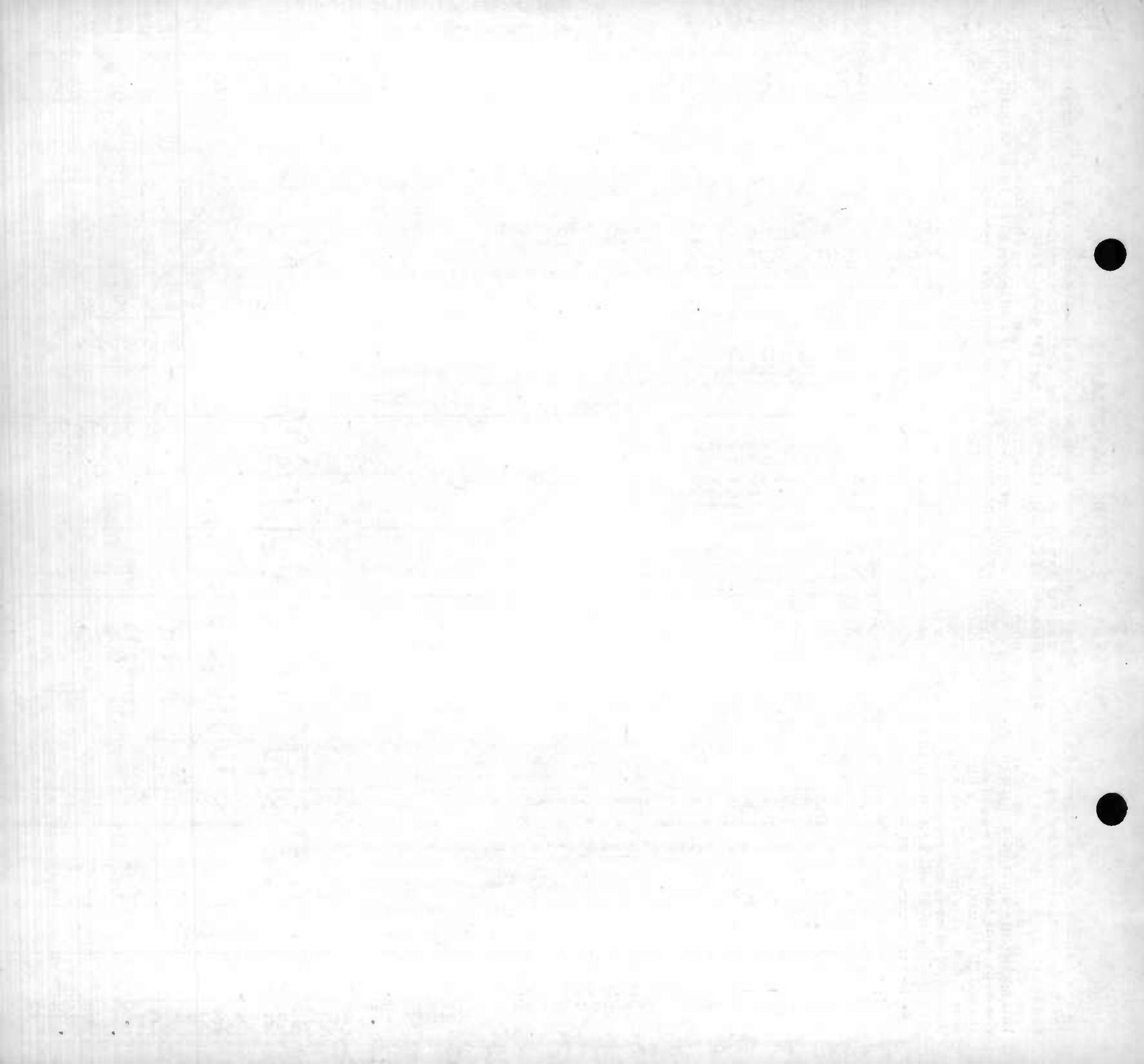
Sept 20, 1902  
Sept 20, 1902  
Sept 20, 1902

Sept 20, 1902  
Sept 20, 1902  
Sept 20, 1902

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

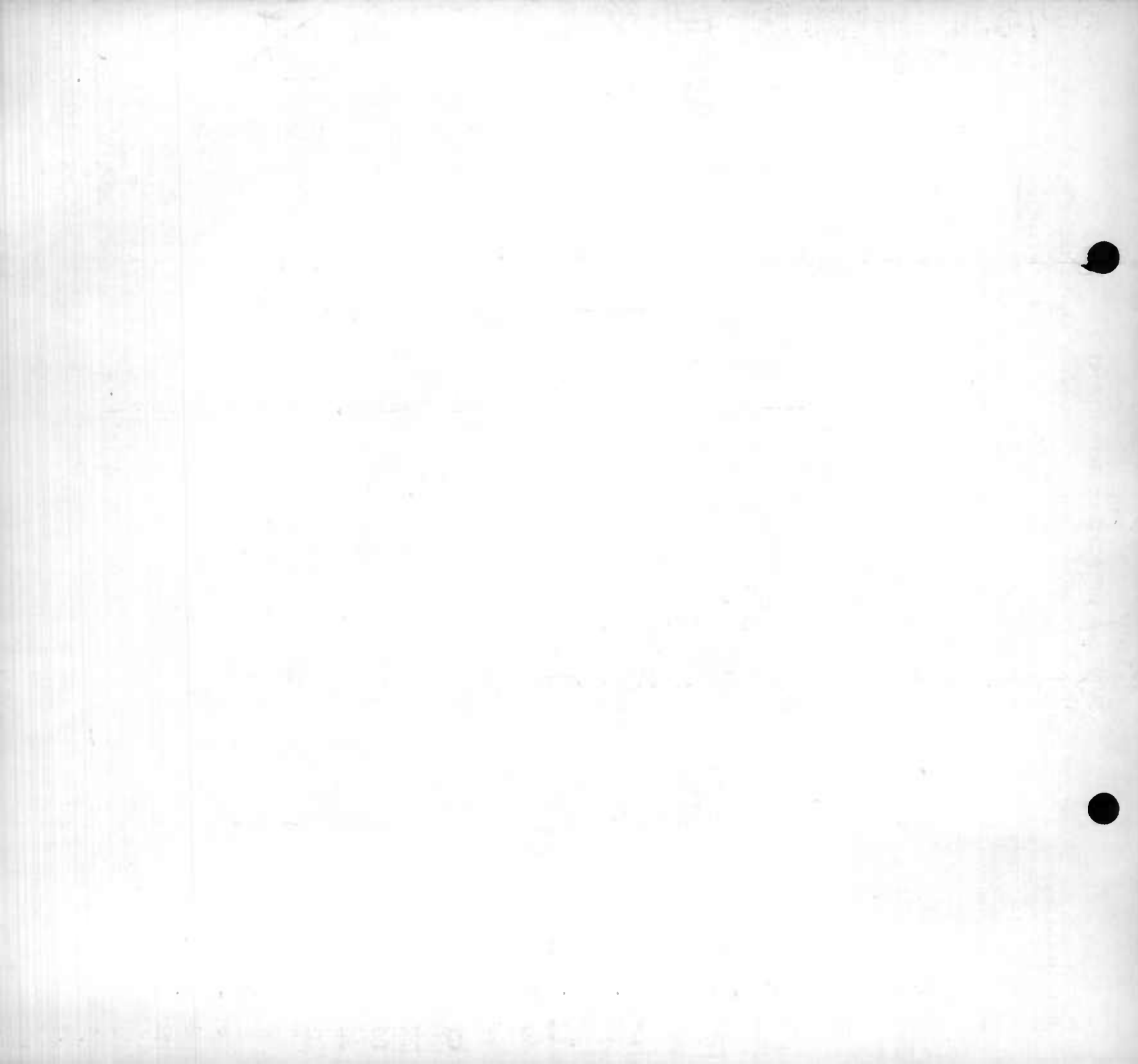
BIRTH NO. 66 10107		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10107	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY MAUDE HUGHES		Oct 6, 1966 12 <sup>00</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL		A. STATE B. COUNTY MARYLAND			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-01			
		D. STREET ADDRESS (If rural, give location) 2638 HUNTINGDON AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 03/07/00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE - HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOSEPH WILLIAMS		14. MOTHER'S MAIDEN NAME MURPHY (Laura Higgs)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-1840		17. INFORMANT ADDRESS OLD CHARTS + daughter.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 170X I		CAUSE OF DEATH (A) Generalized metastases from Ca of breast 15 mos DUE TO (B) Ca of R Breast. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 15 mos	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ASCVD		± 10 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/15 1966 to 10/6 1966, that (I) (we) last saw the deceased alive on 10/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nina Rawlings		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/6/66	
23C. PHYSICIAN'S NAME (Type) NINA RAWLINGS		23D. ADDRESS Md General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-8-1966		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Parkville, Md		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Henry W Jenkins & Sons Co		25D. ADDRESS 4905 York Road Balto. Md.		25E. ADDRESS 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. 66 10108	
BIRTH NO. 68 10108				1. NAME OF DECEASED (Type or Print) EMILY PLEASURE		2. DATE AND HOUR OF DEATH 10-4-66 10.00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY MONTGOMERY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BETHESDA 65-00 D. STREET ADDRESS (If rural, give location) 5515 OAKMONT AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED NEVER MARRIED	8. DATE OF BIRTH 8-22-66	9. AGE (In years lost birthday) ---	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID PLEASURE				14. MOTHER'S MAIDEN NAME JANET ROTNEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -0--		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS David Pleasure, Father see 4 above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Ventricular Fibrillation DUE TO Wolf-Parkinson White (B) Chronic Heart disease DUE TO Tricuspid Insufficiency (C)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 6 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from Sept 30 1966 to Oct 4 1966, that (we) last saw the deceased alive on Oct 4 10pm 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Kaplan						23B. DATE SIGNED 10/4/66	
23C. PHYSICIAN'S NAME (Type) JOSEPH KAPLAN		23D. ADDRESS M.D. Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 7, 1966		24C. NAME of CEMETERY or CREMATORY Natl. Mem. Park		24D. LOCATION (City, town, or county) (State) Falls Church, Va.	
25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Goldberg		ADDRESS Funeral Home 4217 9th St N.W.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 10109					CERTIFICATE OF DEATH		Registered No. 66 10109		
1. NAME OF DECEASED (Type or Print) <b>WILHELMINA FONDELHEIT</b>					2. DATE AND HOUR OF DEATH <b>445 AM 10/5/66</b> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MERCY HOSPITAL</b> <b>37</b>					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Anne Arundel Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE PASADENA</b> D. STREET ADDRESS (If rural, give location) <b>3606 MOUNTAIN RD.</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6/10/10</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>WILLIAM EMRICK</b>					14. MOTHER'S MAIDEN NAME <b>EMMAE WARFIELD</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>228-18-4630</b>		17. INFORMANT <b>Mr. Carl Fondelheit (Husband)</b>			ADDRESS <b>Same as #2</b>	
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION - CARDIAC ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CA. OF BREAST: METASTATIC 3+ years.</b>					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>JUNE 1966</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CO - BREAST</b>			20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> 19 <b>66</b> to <b>10/5</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/4</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dwight Fortier</b> M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>10/5/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>DWIGHT FORTIER</b> M.D.			23D. ADDRESS						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 8/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>			24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>			25C. FUNERAL DIRECTOR <b>Singleton</b> ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>			



Don't Fortier

# FUNERAL DIRECTOR: IMPORTANT

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RGB

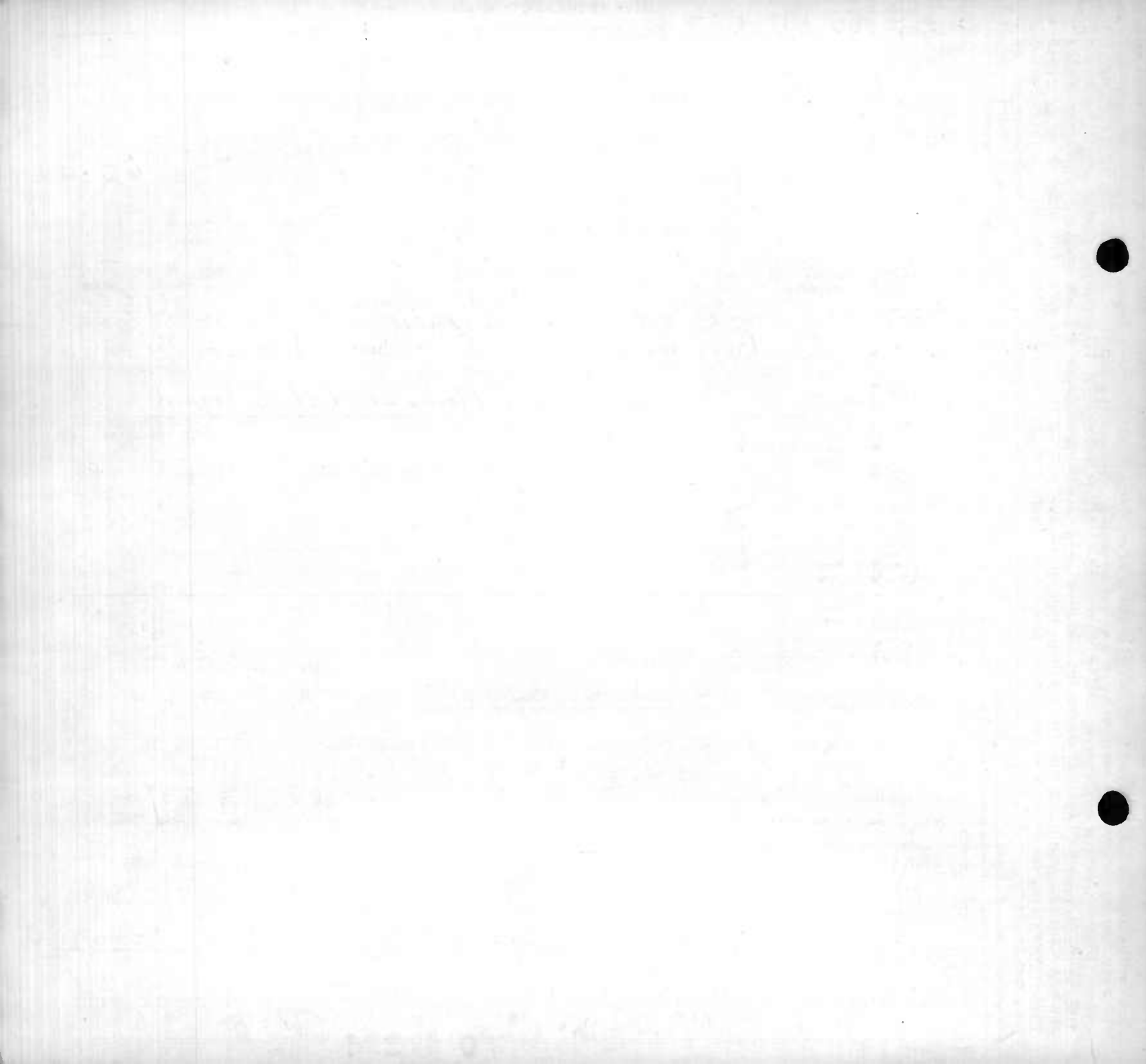
BIRTH NO. 66 10110		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10110	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Lillian Roselee Lee		2. DATE AND HOUR OF DEATH Oct. 4, 1966 12: 06 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7-5-67 US Public Health Service Hospital Wyman Pk. Drive & 31st Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Easton 70-00	
D. STREET ADDRESS (If rural, give location) Rt 2 Box 235A		5. SEX F		6. RACE Col	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 10/9/24		9. AGE (In years last birthday) 41	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Carroll Price		14. MOTHER'S MAIDEN NAME Maggie Sampson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-28-0089		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Disseminated tuberculosis with tuberculous pneumonia Unknown		CAUSE OF DEATH (A) <del>Bronchopneumonia</del> DUE TO		INTERVAL BETWEEN ONSET AND DEATH days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic lymphocytic leukemia DUE TO		years	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 21 1966 to Oct. 4 1966, that (I) (we) last saw the deceased alive on Oct. 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jon M. Beauchamp				23B. DATE SIGNED 10/4/66	
23C. PHYSICIAN'S NAME (Type) Jon M. Beauchamp, Surgeon (R)		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-8-66		24C. NAME OF CEMETERY or CREMATORY Chapel Cemetery	
24D. LOCATION Ta/bot Md		25A. DATE REC'D BY HEALTH DEPT. OCT 7 1966		25B. NAME OF REGISTRAR Robert E. Fagley	
25C. FUNERAL DIRECTOR James B. Washiel		25D. ADDRESS 1012 E. Sullivan			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10111		CERTIFICATE OF DEATH		Registered No. 66 10111		
1. NAME OF DECEASED (Type or Print) <u>Philip E. Bynaker</u>				2. DATE AND HOUR OF DEATH <u>10/2/66</u> <u>17:45 P.M.</u>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> <u>Baltimore, Md.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Sykesville</u> D. STREET ADDRESS (If rural, give location) <u>Box 440</u>						
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>11/12/12</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Const. worker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Const. worker</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William W. Bynaker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Weaver</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>213-16-0002</u>		17. INFORMANT <u>Medical History Record</u>				ADDRESS	
18. <u>381.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Cirosis of liver</u> DUE TO (B) <u>Bronchial Pneumonia</u> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> <u>1966</u> to <u>10/2</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>10/2</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.										
23A. SIGNATURE <u>David E. Zichsfosse</u> M.D. 23C. PHYSICIAN'S NAME (Type) <u>David E. Zichsfosse</u>						23B. DATE SIGNED <u>10/2/66</u>		23D. ADDRESS M.D. <u>University Hospital, Balto, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-5-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Crestawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 1966</u>			25B. NAME OF REGISTRAR <u>Philip E. Bynaker</u>			25C. FUNERAL DIRECTOR <u>Harry W. Hight</u>		ADDRESS <u>Sykesville, Md.</u>		



17-11-18  
FR

K-500 66 10112

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 10112

M.E. CASE NO. Kane, Lottie

1. NAME OF DECEASED  
(Type or Print)

KANE, LETTIE

2. DATE AND HOUR OF DEATH

10-4-66 9 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland  
C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore  
D. STREET ADDRESS (If rural, give location)

4940 Eastern Ave. 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
(WIDOWED, DIVORCED (specify))

Divorced

8. DATE OF BIRTH

9-16-75

9. AGE (In years  
lost birthday)

91

10. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

John A. Robinson

14. MOTHER'S MAIDEN NAME

Sarah Plowman

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

1B. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) MYOCARDIAL INFARCTION  
DUE TO

(B) RECTAL BLEEDING  
DUE TO

(C) ANEMIA, AS HD

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

ANEMIA AS HD

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 4 1966 to Oct 4 1966,  
that (I) (we) last saw the deceased alive on Oct 4 1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Charles D. Robinson M.D.

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

Oct 4, 1966

23C. PHYSICIAN'S  
NAME (Type)

Charles D. Robinson M.D.

23D. ADDRESS

Baltimore City Hospitals 21224  
BCH 4940 Eastern Avenue Balto. Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

OCT 10/7/66

Meadowridge Mem. Pk.

Howard Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

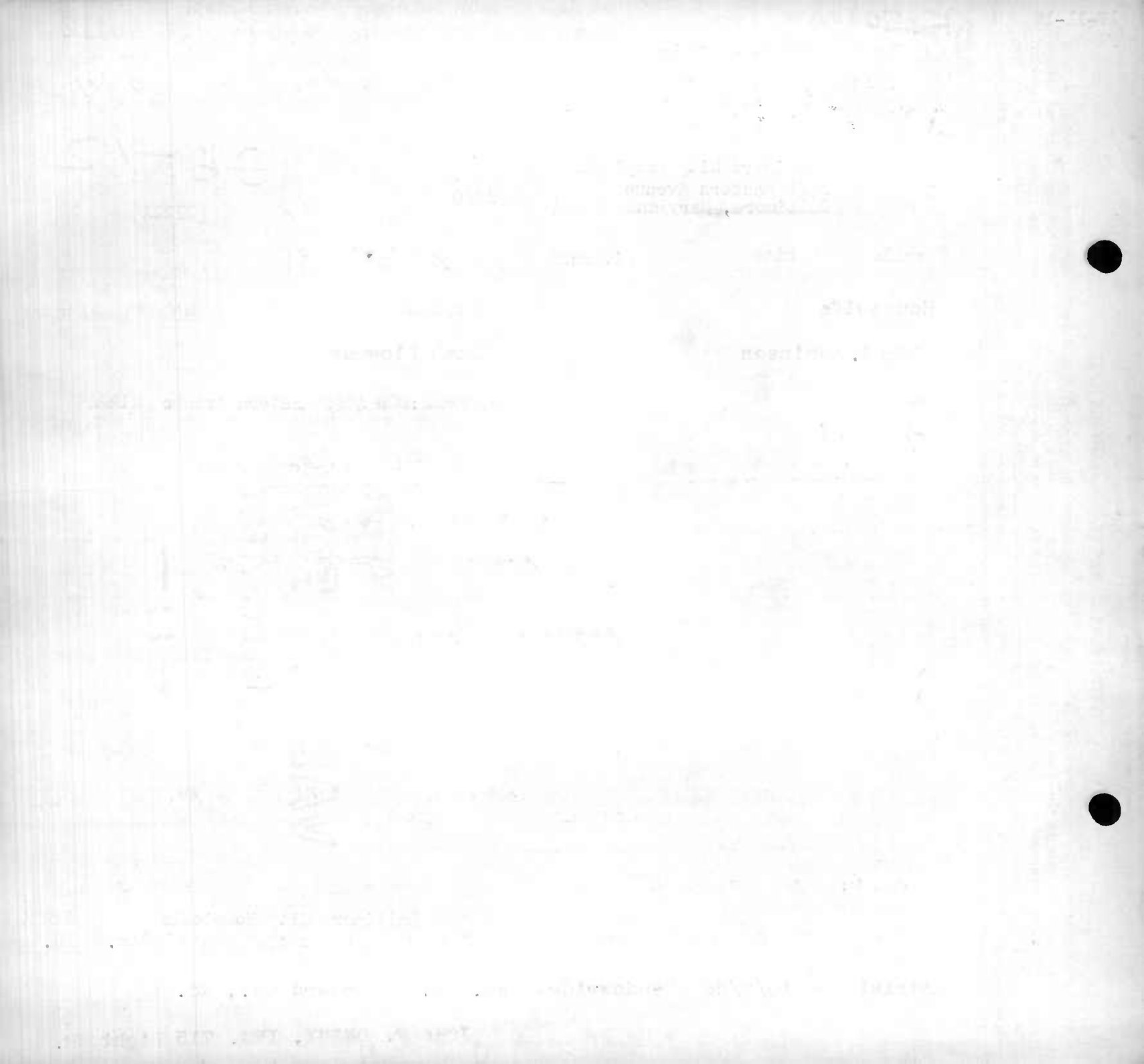
ADDRESS

Robert E. Fink

JOHN F. DENNY, INC. 715 Light St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





## CERTIFICATE OF DEATH

Registered No. 66 10113

BIRTH NO. 66 10113

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOHN William Joseph Jaworski

2. DATE AND HOUR OF DEATH

10-6-66

4:15 AM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

**CERTIFICATE AMENDED**

HOSPITAL OR INSTITUTION

Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

114 S. Ellwood Avenue #21224

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-17-01

9. AGE (In years  
lost birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Tire Checker

10B. KIND OF BUSINESS OR INDUSTRY

Fisher Body

11. BIRTHPLACE (State or foreign country)

Maryland Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Jaworski

14. MOTHER'S MAIDEN NAME

Mollie Karwacki

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

216-09-8648

17. INFORMANT

#21224

ADDRESS

RECORDS-BCH-4940 Eastern Avenue

18. 420.1 & 1260 X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Acute myocardial Infarction

(B) DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

7 hrs -

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-6-66 14m 19 to 10-6-66 4Am 19  
that (I) (we) last saw the deceased alive on 10-6-66 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William A. Emerson

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10-6-66

23C. PHYSICIAN'S  
NAME (Type)

Dr. William A. Emerson

M.D.

BCH-4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/10/66

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OCT 7 1966

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Sec. Sec. for WILLIAM JOHN JAWORSKI - # 216-09-2648

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10114		CERTIFICATE OF DEATH		Registered No. 66 10114	
1. NAME OF DECEASED (Type or Print) <b>Gunthope, LULA</b>				2. DATE AND HOUR OF DEATH <b>10-4-66 @ 4:10 PM</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>John Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>6-205</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Md 21231</b> D. STREET ADDRESS (If rural, give location) <b>204 Douglas Ct</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>		8. DATE OF BIRTH <b>12-25-08</b>		9. AGE Years <b>57</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CHARLOTTE N. C.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>LEE GREEN</b>				14. MOTHER'S MAIDEN NAME <b>ELLA WHITE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elizabeth Haywood</b>			ADDRESS <b>916 W. Fayette</b>		
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <b>Coma, prob CVA. many yrs</b> (B) DUE TO <b>Diabetes - hyperosmolar 1 wk</b> (C) <b>hyperglycemic coma</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9/26 1966</b> to <b>10/4 1966</b> that (I) (we) last saw the deceased alive on <b>10/4 1966</b> and that in (my) <b>ap</b> opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>view</del> ) view the body after death.									
23A. SIGNATURE <b>David L. Fedson</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>10/4/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>DAVID L. FEDSON</b> M.D.				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>10/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Ce</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>WM. C. MARCH</b>			ADDRESS <b>928 E. NORTH Ave</b>		

10/15

22 2

Handwritten notes, possibly a list or description, in cursive script.

Handwritten notes, possibly a list or description, in cursive script.

10/15

10/15

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10115		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10115	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Paine, James Callaway</i>		2. DATE AND HOUR OF DEATH <i>October 4, 1966 12<sup>15</sup> pm.</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hospital</i>		A. STATE <i>Baltimore</i> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>City 11-03</i>			
<i>49</i>		D. STREET ADDRESS (If rural, give location) <i>716 Park Ave -</i>			
5. SEX <i>Male</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>11/1/00</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Rusco Storm Windows</i>		11. BIRTH PLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Paine</i>		14. MOTHER'S MAIDEN NAME <i>Grace Horner</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-09-9109</i>		17. INFORMANT <i>Hospital Record</i>	
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>ARTERIOSCLEROTIC CARDIO VASCULAR DIS.</i> (B) <i>Metabolic Acidosis</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Sept. 26, 1966</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ADULT-HEAR OBSTRUCTION</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 23, 1966</i> to <i>Oct 4, 1966</i> , that (I) (we) lost saw the deceased alive on <i>Oct 4, 1966 12<sup>15</sup> pm</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Artemio Muriago</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Oct 4, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>JAMES E. F. HOPKINS</i>		23D. ADDRESS <i>2724 N Charles St</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-7-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>J. J. Howard 3207 W. North Ave.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 10116		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 666630116	
1. NAME OF DECEASED (Type or Print) <b>Green Amanda D.</b>				2. DATE AND HOUR OF DEATH <b>10/5/66 8:40 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Dukeland Nursing + Convalescent Home 90 1501 DUNDAL ST.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland, Baltimore</b> B. COUNTY <b>21223</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO 19-01</b> D. STREET ADDRESS (If rural, give location) <b>1408 W. SARATOGA ST</b>					
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7/22/1895</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>William COTHORN</b>				14. MOTHER'S MAIDEN NAME <b>FASTER RUSSELL</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mildred PARKER 1408 W. SARATOGA ST</b>				
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Hypertensive Heart Disease</b> DUE TO (B) <b>Essential Hypertension</b> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerosis</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>JAN 1962</b> to <b>4 OCT 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4 OCT 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>John H. Holmes III</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7 OCT 66</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOHN H. HOLMES III</b>				23D. ADDRESS <b>927 N. MONROE BALTIMORE Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>10/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO NATIONAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Manhara P. Hays</b>			25D. ADDRESS <b>37 N. Gilem St</b>	



1871

William Cornwell  
Homesman at home  
no

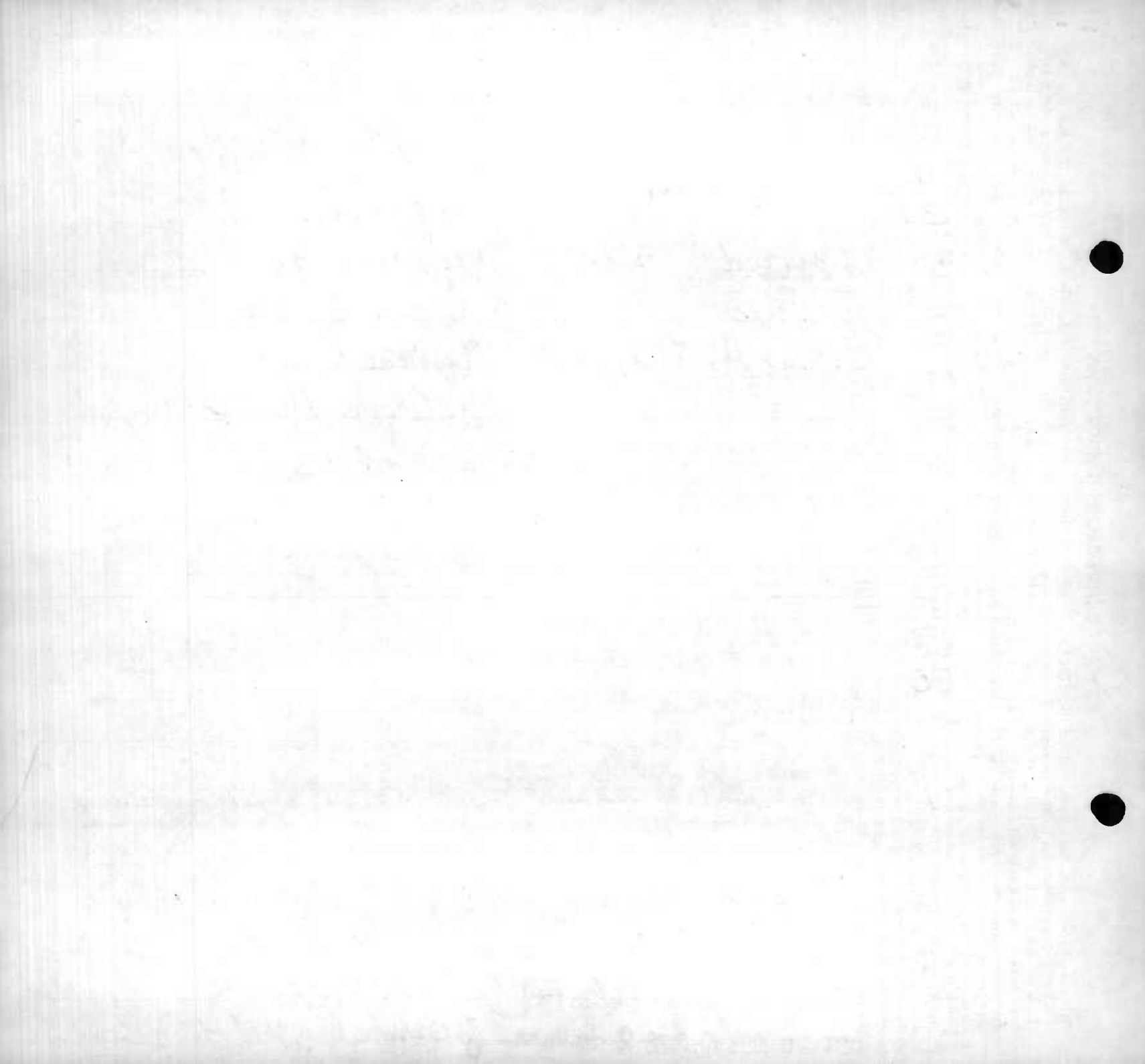
1870  
1405 on 2nd street  
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1405 on 2nd street

Printed by the  
Printer at the  
1405 on 2nd street

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10117</u>	
BIRTH NO. <u>66 10117</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Salona Gomez</u>		2. DATE AND HOUR OF DEATH <u>Oct 6 - 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M. <u>15-01</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> <u>31</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>15-01</u>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto Md</u>			
		D. STREET ADDRESS (If rural, give location) <u>708 Gold St</u>			
5. SEX <u>Mal</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>yes</u>	8. DATE OF BIRTH <u>Mar 7 - 1887</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Roanoke Va.</u>	
13. FATHER'S NAME <u>Thomas H. Wiggins</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Ball</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Alcega Hawkins</u>	
				ADDRESS <u>San Francisco</u>	
18. <u>420.01</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <u>Cerebral Thrombosis</u> <u>Left</u>		<u>5 mos</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO <u>Arterio Sclerotic Heart</u> <u>Disease</u>		<u>2 yrs</u>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-6-66</u> 19 to <u>10-6-66</u> 19, that (I) (we) last saw the deceased alive on <u>10-6-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. Franklin Phillips</u> M.D.				23B. DATE SIGNED <u>10/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. Franklin Phillips</u>				23D. ADDRESS <u>558 McMonahan St. Balto Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus M. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Talone</u>		25C. FUNERAL DIRECTOR <u>J. Brooks Ringgold</u>	
				ADDRESS <u>1413 N. Carey St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 10118		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 10118	
1. NAME OF DECEASED (Type in Print) <b>HUBER G. AUGUST</b>				2. DATE AND HOUR OF DEATH <b>7 OCT 66</b> <b>3<sup>50</sup> P M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP. OF BALTIMORE</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>27-18</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>3634 MANCHESTER AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUC</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-24-85</b>	9. AGE (In years last birthday) <b>31</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Maintenance Man- Bell Foundry</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Michael L. Huber</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Becker</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-01-6889</b>		17. INFORMANT <b>Hospital chart</b>		ADDRESS		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>48-72h.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Complete Head Block</b>		<b>72-96h</b>			
				(C) <b>Coronary atherosclerotic cardiovascular disease</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Renal Disease 2°</b>		<b>year</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 3 1966</b> to <b>OCT 7 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT 7 1966</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Michael L. Huber</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7 OCT 66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Michael L. Huber</b>		M.D.		23D. ADDRESS <b>Sinai Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Edman Lemmon</b>		ADDRESS <b>4611 Park Heights Ave.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 10119</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>66 10119</b>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Mrs. Margaret M. Coughlin</b>			2. DATE AND HOUR OF DEATH <b>October 8, 1966</b>   <b>4:30 A.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-16</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Seton Psychiatric Institute 6420 Reisterstown Road Baltimore, Maryland 21215</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>4600 Pall Mall Road, Baltimore, Md. 21215</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10/26/83</b>	9. AGE (In years lost birthday) <b>82 years</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Andrew Cunningham</b>			14. MOTHER'S MAIDEN NAME <b>Catherine ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
			17. INFORMANT - Daughter - ADDRESS <b>4600 Pall Mall Road Miss Margaret Coughlin; Baltimore, Md. 21215</b>		
18. <b>352X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral thrombosis</b> DUE TO <b>Cerebral and general arteriosclerosis</b> DUE TO <b>4 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Chronic brain syndrome due to cerebral arteriosclerosis with psychosis</b> <b>2 1/2 years</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 17</b> 19 <b>65</b> to <b>October 8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>October 8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter O. Jahrreiss</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>October 8, 1966</b>
23C. PHYSICIAN'S NAME (Type) <b>Walter O. Jahrreiss</b>			23D. ADDRESS <b>6420 Reisterstown Road Baltimore, Maryland, 21215</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/11/66</b>	24C. NAME of CEMETERY or CREMATORY <b>Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Robert E. Farley</i> ADDRESS <b>4611 Park Heights Ave.</b>	

**OCT 10 1966**





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT					Registered No. <u>66 10120</u>	
BIRTH NO. <u>66 10120</u>		CERTIFICATE OF DEATH				
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>IRWIN A. KRESS</u>			2. DATE AND HOUR OF DEATH <u>OCT. 1, 1966</u> <u>10:08 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>8-04</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>PINAL HOSPITAL OF BALTIMORE, INC.</u> <u>42</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
		D. STREET ADDRESS (If rural, give location) <u>2228 E. OLIVER ST # 13</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3-17-92</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Tr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>UNKNOWN Nicholas Kress</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN Virginia Donson</u>		ADDRESS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>216-07-6043</u>		17. INFORMANT <u>ANNA DOETCH 3434 PARKLAWN</u>		
18. <u>573X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>Terminal pneumonia</u>		CAUSE OF DEATH <u>Terminal pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>AVE</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>general debilitation</u>		(B) <u>general debilitation</u>				
		(C) <u>chronic renal failure + biliary fistula</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>biliary fistula, penetrating duodenal ulcer</u>						
19A. DATE OF OPERATION <u>9-8-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPST? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 6</u> 19 <u>66</u> to <u>Oct. 1</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>October 1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Reynaldo P. Madriana</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>OCT. 1, 1966</u>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-5-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1966</u>		25B. NAME OF REGISTRAR <u>John G. Miller</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John G. Miller Inc. - 6415 Belair Rd. - 21206</u>		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66-10121	
BIRTH NO. 66 10121		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FRANCES SHOUR or SOUR</b>		2. DATE AND HOUR OF DEATH <b>10-6-66 3.30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>7-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 5</b> D. STREET ADDRESS (If rural, give location) <b>724 N. STREEPER ST.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>1-17-86</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpet Repair</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Peterson &amp; Moore</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph ROSILEK ?</b>		14. MOTHER'S MAIDEN NAME <b>Anna Bednar ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-24-3161A</b>		17. INFORMANT <b>George E. Shour, son, above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b> DUE TO <b>myocardial infarct</b> INTERVAL BETWEEN ONSET AND DEATH <b>min -</b> <b>? days</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/6/66</b> to <b>10/6/66</b> that (I) (we) last saw the deceased alive on <b>10/6/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harmon J. Eyre</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/6/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harmon J. Eyre</b>		23D. ADDRESS <b>601 North Broadway Balt. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>			
25D. ADDRESS <b>2001 E. Madison Street</b>					

Cardiac Mount  
Superiorial Inset

None

No

Yes

10/10

10/10

10/10

Harmon J. Faye  
Harmon J. Faye

X

201 North Broadway  
East. N.Y.

10/10/10

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M-536		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10122	
1. NAME OF DECEASED (Type or Print) <b>MANDRAS JOHN</b>		2. DATE AND HOUR OF DEATH <b>10/6/66 7:50 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>26-07</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. 24</b>			
		D. STREET ADDRESS (If rural, give location) <b>702 S. Oldham Street</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-15-1893</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restauranter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Mandras, Soterios</b>		14. MOTHER'S MAIDEN NAME <b>Detropakis, Sophia</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>236-03-5610</b>		17. INFORMANT <b>Mrs. Sophia Mandras</b>	
				ADDRESS <b>702 S. Oldham St., Baltimore, Md.</b>	
18. <b>163 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cancer of the lungs</b>		(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>SEPT. 8, 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of the R. lung</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>August 30, 1966</b> to <b>October 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>October 6, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Adolfo G. de Perio</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct. 6, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Adolfo G. de PERIO</b>		23D. ADDRESS <b>BON SECOURS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greek Orthodox Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>	
				ADDRESS <b>3024 Eastern Ave., Baltimore, Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10123	
BIRTH NO. 66 10123				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WETTERS, MRS. CATHERINET, Oct.</b>		2. DATE AND HOUR OF DEATH <b>6, 1966 1:50 P.M.</b>	
3. PLACE OF DEATH IN (BALTIMORE, MARYLAND)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>EAST WOOD</b>	
FULL NAME OF (If not in hospital or institution, give street address or location) <b>Church Home + Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>423 OVERVIEW RD.</b>		E. CITY <b>BALTIMORE</b> F. STATE <b>MD.</b> G. ZIP CODE <b>21224</b>	
5. SEX <b>Female</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>9/10/08</b>	9. AGE (In years last birthday) <b>58</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CASHIER</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Mudley's Bakery</b>		13. BIRTHPLACE (State or foreign country) <b>MD., Baltimore</b>	
14. FATHER'S NAME <b>JAMES HELFRICH</b>		15. MOTHER'S MAIDEN NAME <b>Margaret Eckardt</b>		16. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>218-42-4054</b>		19. INFORMANT <b>MYRA L. NORRIS</b> ADDRESS <b>BALTO. 1387 DEANWOOD RD 34 MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>422.1 I</b>		CAUSE OF DEATH <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>due to Arteriosclerotic Cardiovascular Disease</b>		<b>2 wks.</b>	
		(B) DUE TO <b>Consolidative R lower lobe pneumonia</b>			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Renal Insufficiency - Etiology undetermined</b>		<b>months</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 24 1966</b> to <b>Oct 6 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct 6, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Francisco Ballay, Jr.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>Oct 6, 1966</b>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS _____			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-10-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>SACRED HEART CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairman</b>		25C. FUNERAL DIRECTOR <b>901 S. CONKLE ST. BALTO., 21224, MD.</b>			



100  
Total  
August

100  
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August

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August

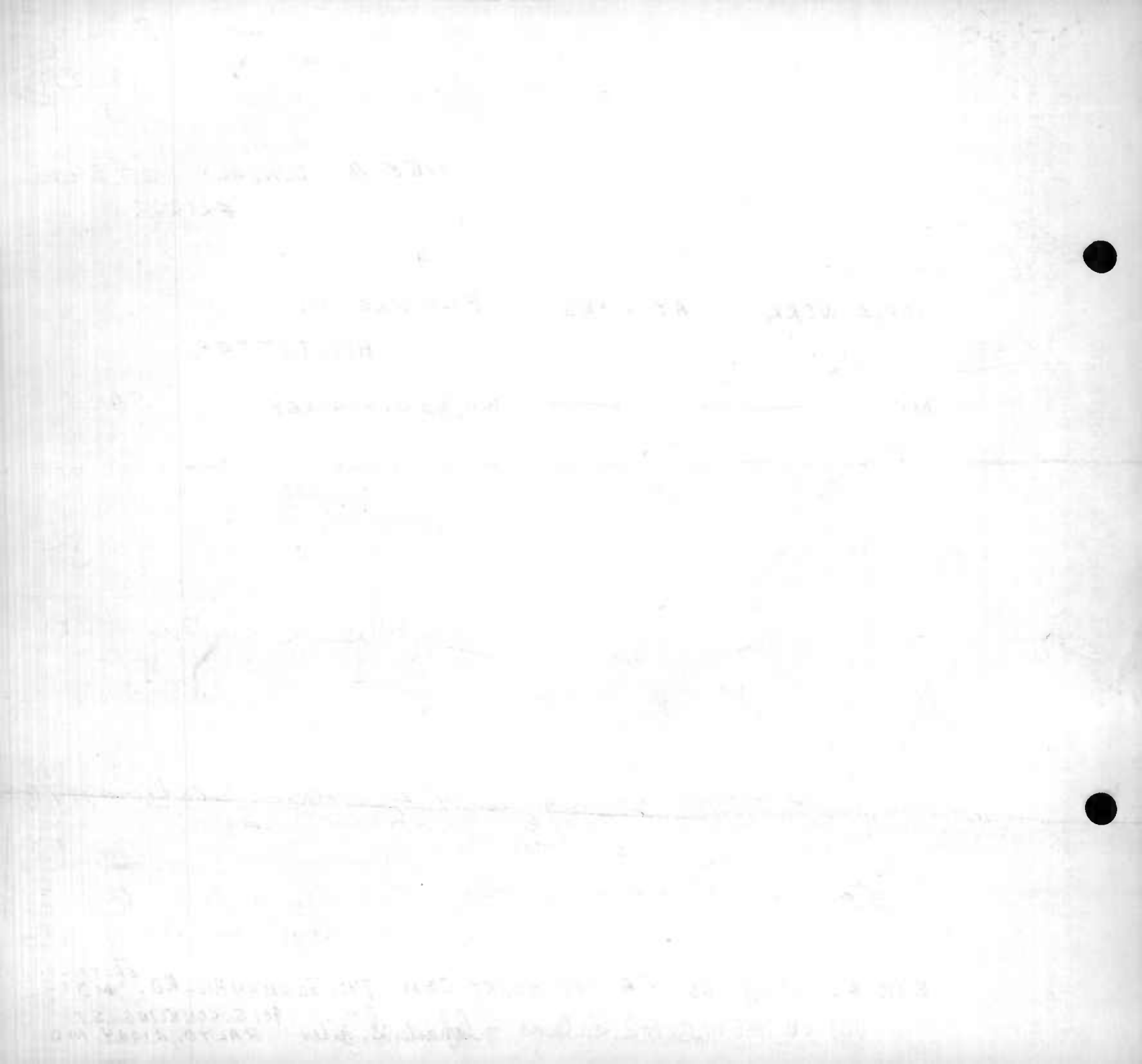
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August

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August

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 10124		CERTIFICATE OF DEATH		66 10124	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Kofsky, Mary M.		10/6/66 8:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  THE JOHNS HOPKINS HOSPITAL 33		A. STATE B. COUNTY BALTIMORE COUNTY MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <del>BALTIMORE</del> DUNDALK 53-00			
		D. STREET ADDRESS (If rural, give location) 21 CENTER AVENUE #21222			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-29-42	9. AGE (In years last birthday) 23	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME WILLIAM ROGERS			
14. MOTHER'S MAIDEN NAME LUCY HOFSTETTER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT WAYNE J. KOFKEY		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cardiac arrhythmia Congenital Heart Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days life	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Cerebral embolism, Hemiplegia lwb					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/2/66 to 10/6/66, that (I) last saw the deceased alive on 10/6/66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE David L. Fedson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DAVID L. FEDSON		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-11-66		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM	
24D. LOCATION 7401 GERMAN HILL RD. BALTO. CO., MD					
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1966		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR 3 Charles S. Siler	
25D. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>66 10125</b>		<b>CERTIFICATE OF DEATH</b>		66 10125	
1. NAME OF DECEASED (Type or Print) <b>MR. JOHN MEISENHALDER</b>			2. DATE AND HOUR OF DEATH <b>10-5-66 11:45 p.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>35 CHURCH HOME &amp; HOSP BALTIMORE, MD. 21231</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO. CO.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>611 S. 46th ST. #21224</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-24-02</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>EASTERN STAINLESS STEEL</b>	11. BIRTHPLACE (State or foreign country) <b>MD., BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>FREDERICK MEISENHALDER</b>			14. MOTHER'S MAIDEN NAME <b>MARY LEUTZ</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) <b>YES W. W. II</b>		16. SOCIAL SECURITY NO. <b>213-07-8418</b>	17. INFORMANT <b>PATIENT</b>		ADDRESS <b>SAME</b>
18. <b>302.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema with Chronic Bronchitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>5 years</b>			(A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2 MAR.</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>P.A.</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-20 1966</b> to <b>10-5 1966</b> , that (I) (we) last saw the deceased alive on <b>10-5 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard M. Tison</b>				23B. DATE SIGNED <b>10-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. T. HOPKINS (Richard N. Tison) (Staff)</b>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10-10-66</b>	24C. NAME of CEMETERY or CREMATORY <b>OAK LAWN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD. BALTO. CO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Charles J. Geiler</b>	
ADDRESS <b>6224 EASTERN AVE. BALTO., 21224, MD.</b>					

Ho

June 2 1890

25 - 40 yd of ...

2 - 100 yd of ...

100 yd of ...  
100 yd of ...  
100 yd of ...

100 yd of ...

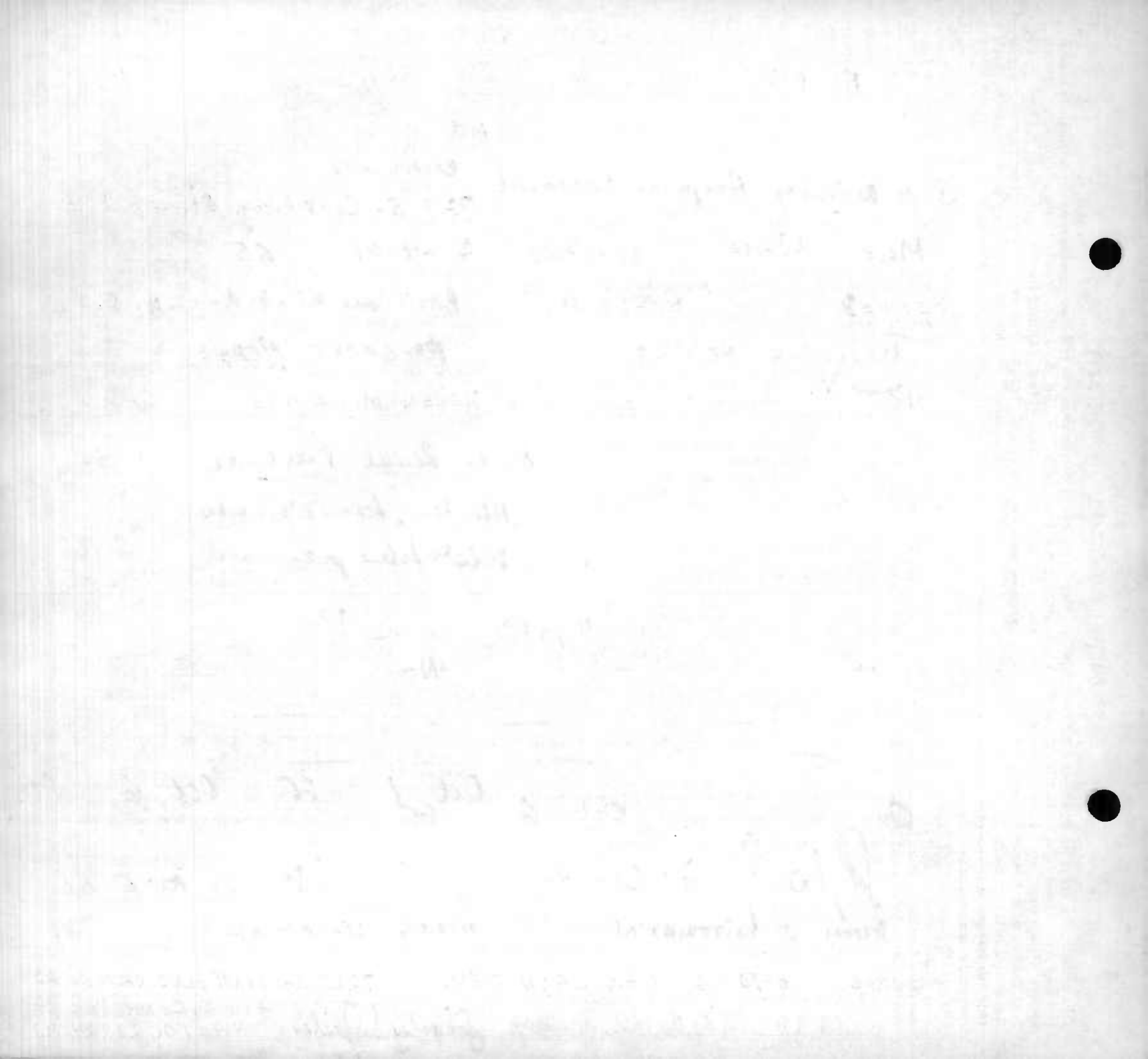
100 yd of ...

100 yd of ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10126		CERTIFICATE OF DEATH		Registered No. 66 10126	
1. NAME OF DECEASED (Type or Print) HEINZE, Marion, Wm.				2. DATE AND HOUR OF DEATH 10-6-66 1:16 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital Balto. Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 26-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 727 S. Conkling St. #21224.					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-24-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY FAIRBANKS-MOORE SCALE CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FREDERICK HEINZE				14. MOTHER'S MAIDEN NAME MARGARET HEAMER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 059-05-4516		17. INFORMANT HELEN M. HEINZE		ADDRESS SAME			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute Renal Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ascites, Kimmel's disease Bilat. Lobar pneumonia				(A) DUE TO		(B) DUE TO		(C) DUE TO	
19. INTERVAL BETWEEN ONSET AND DEATH 1 day									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hepatic Coma ??									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Oct 1 19 66 to Oct 6 19 66, that (I) (we) last saw the deceased alive on Oct. 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Stephan J. Wittmann M.D.				23B. DATE SIGNED 10-6-66					
23C. PHYSICIAN'S NAME (Type) STEPHAN J. WITTMANN		23D. ADDRESS M.D. Mercy Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-10-66		24C. NAME of CEMETERY or CREMATORY OAK LAWN CEM.		24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. BALTO. CO., MD.			
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1966		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Charles J. Seiler		ADDRESS 901 S. CONKLING ST. BALTO., MD.			





M-560

66 10127

BALTIMORE CITY HEALTH DEPARTMENT

66 10127

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PHILLIP MINOR

2. DATE AND HOUR PRONOUNCED DEAD

October 6, 1966 2:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 99 Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 13-01

D. STREET ADDRESS (If rural, give location)

2110 Park Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

6-15-1877

9. AGE (In years  
last birthday)

89

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer - Retired

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Caroline Co., Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Woodson Minor

14. MOTHER'S MAIDEN NAME

Hanna Truehart

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Odessa Williams 2110 Park Ave. 21217

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH420.01  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 6, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-10-66

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Marshall Jones, Jr. 1735 Harford Ave. 21213

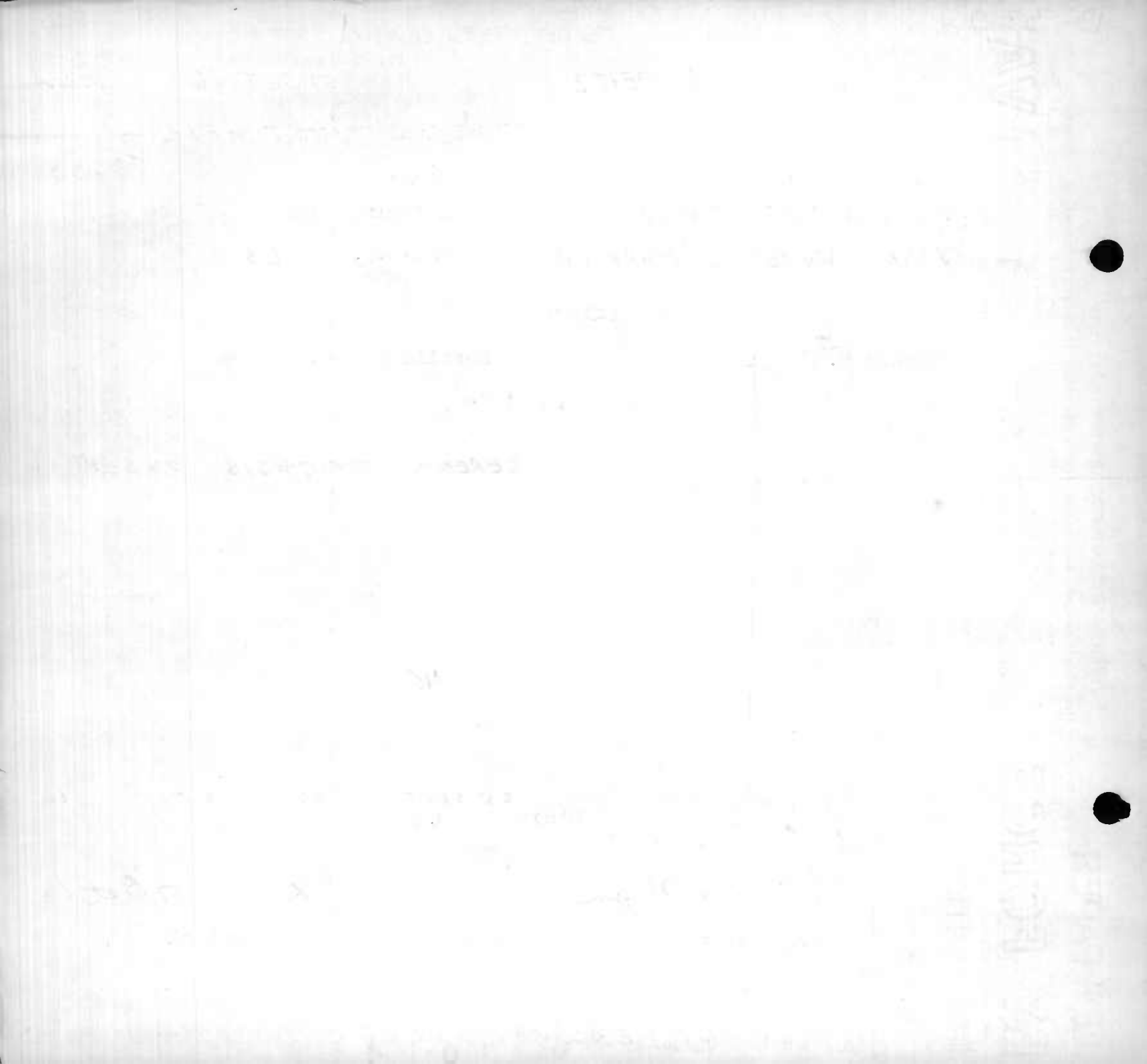
OCT 10 1966 R. E. E. F. F.

19660030140

WATLEY POLICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10128		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10128	
1. NAME OF DECEASED (Type or Print) <b>LEONARD H. DEITZ</b>			2. DATE AND HOUR OF DEATH <b>7 OCT 66 10:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 53-00</b> D. STREET ADDRESS (If rural, give location) <b>5561 Gayland Road</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11 JULY 1903</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Vault &amp; Safes</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Howard M. Deitz</b>			14. MOTHER'S MAIDEN NAME <b>Rosalie Bomberg</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-5786</b>		17. INFORMANT <b>MARGARET E. DEITZ 5561 Gayland Rd.</b>	
18. <b>332X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>CEREBRAL THROMBOSIS</b> DUE TO (B) DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH <b>24 SEPT 66</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>25 SEPT 19 66</b> to <b>7 OCT 19 66</b> , that (I) (we) last saw the deceased alive on <b>7 OCT 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mervyn Bagan</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>7 Oct 66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Mervyn Bagan</b>			23D. ADDRESS M.D. <b>The Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/10/66</b>	24C. NAME of CEMETERY or CREMATORY <b>LAKEVIEW Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>AMBASSADE Inc. 1328 Sulphur Spring Rd.</b>	



66 10129

BALTIMORE CITY HEALTH DEPARTMENT

66 10129

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Henry G. Bolander

2. DATE AND HOUR PRONOUNCED DEAD

10/3/66 4:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

27-34

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3809 Hamilton Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Singel

8. DATE OF BIRTH

Feb. 16, 24

9. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Christian

14. MOTHER'S MAIDEN NAME

Louise Hesterberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

---

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16. SOCIAL  
SECURITY NO.

---

17. INFORMANT

Mother

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Anatomically and chemically undetermined  
- DUE TO - cause of death

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/4/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/7/66

23C. NAME of CEMETERY or CREMATORY

St. Paul Cemetery

23D. LOCATION

(City, town, or county)

(State)

Violetville Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 10 1966

Robert E. Farber, M.D.

P. N. Heemann

6067 Harford

W. A. P. H. H.

44

1870

1870

W. A. P. H. H.

W. A. P. H. H.

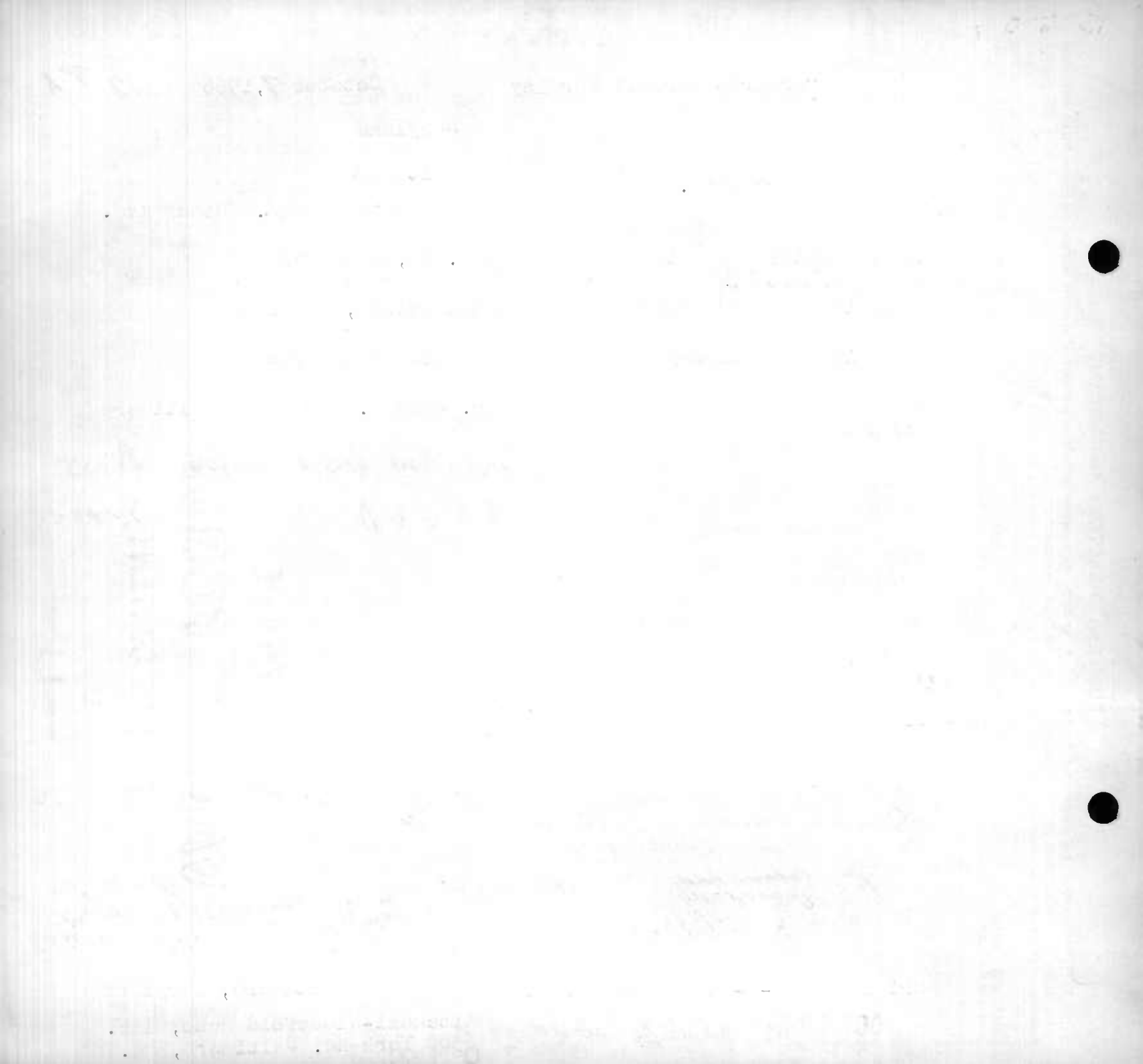
W. A. P. H. H.

W. A. P. H. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 66 10130		Registered No. 66 10130							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Margaret Carroll Bordley				2. DATE AND HOUR OF DEATH October 7, 1966 12 30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wyman Park Apts.						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Wyman Park Apts. Beech Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Aug. 12, 1875	9. AGE (In years last birthday) 91	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Centreville, Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Richard Hollyday				14. MOTHER'S MAIDEN NAME Elizabeth Earle					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. John E. Bordley		ADDRESS Baltimore			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Congestive heart failure (B) DUE TO AS CVD (C)		INTERVAL BETWEEN ONSET AND DEATH Days Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 9-18-65 to 10-7-66, that (1) (we) last saw the deceased alive on 10-6-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE RK Gundry				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-7-66			
23C. PHYSICIAN'S NAME (Type) RK GUNDY		M.D.		23D. ADDRESS 2 W. University Pkwy Baltimore, Md 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-8-66		24C. NAME OF CEMETERY OR CREMATORY Green Mount		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.					

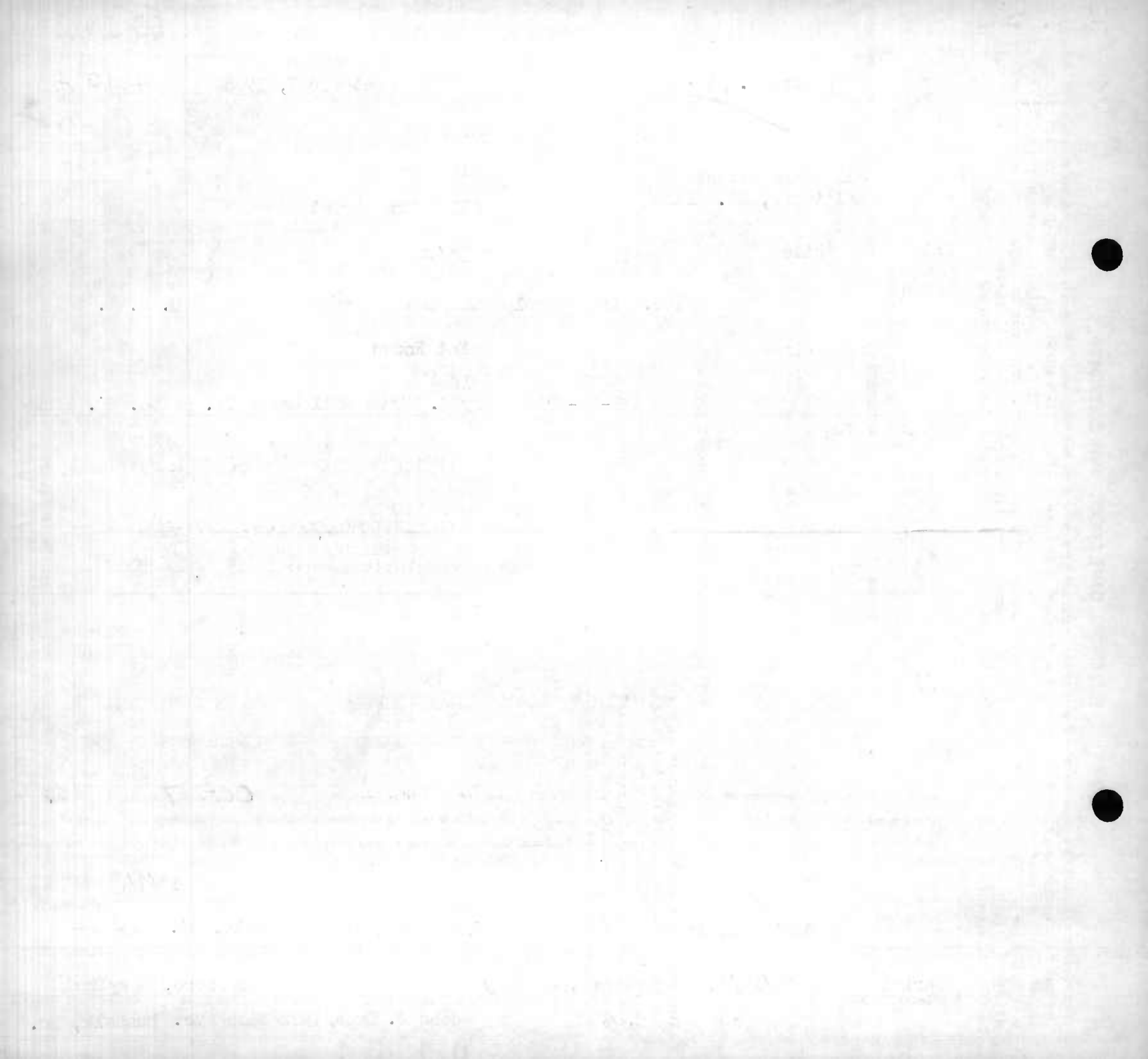




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10131</u>	
BIRTH NO. <u>66 10131</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>1</u>			2. DATE AND HOUR OF DEATH <u>October 7, 1966</u> <u>4.10 A</u> M.		
1. NAME OF DECEASED (Type or Print) <u>Robert A. Hines</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			A. STATE <u>Maryland</u> B. COUNTY <u>26-05</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>611 Umbra Street</u> <u>Baltimore, Md. 21224</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>611 Umbra Street</u>			10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Balto. Fire Patrol</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	B. DATE OF BIRTH <u>3/10/95</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Fire Patrol</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>David Hines</u>			14. MOTHER'S MAIDEN NAME <u>Not Known</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>			16. SOCIAL SECURITY NO. <u>213-07-0330</u>		17. INFORMANT (Wife) <u>Mary E. Hines</u> <u>611 Umbra St. Balto. Md. 21224</u>
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial infarct.</u> <u>generalized A.S.</u> <u>Coronary Insufficiency.</u> <u>Severe Hypertension.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few minute.</u> <u>years</u> <u>years.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 4, 1964</u> 19 <u>66</u> to <u>Oct 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ataollah Golpira</u> M.D.				23B. DATE SIGNED <u>10/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ataollah Golpira</u>				23D. ADDRESS M.D. <u>1942 Cedar Lane Dundalk, Md. 21222</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/10/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Boonsboro, Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Boonsboro, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John J. Duda 7922 Wise Ave. Dundalk, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 10132</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>66 10132</b>	
M.E. CASE NO.		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>TAMMY RUTHANN MASSEY</b>		2. DATE AND HOUR OF DEATH <b>Oct. 7-1966</b>		<b>2:45 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Balta. Co</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Dundalk</b>			
		D. STREET ADDRESS (If rural, give location) <b>1935 Inverton Road 21222</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Never Married</b>	8. DATE OF BIRTH <b>March 23-1966</b>	9. AGE (In years lost birthday) <b>6 MONTHS</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. Massey Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Linda R. Wisner</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT ADDRESS # <b>4, a, b, c, d.</b> <b>Parents, Mr. &amp; Mrs. Wm. H. Massey Jr.</b>	
18. <b>356.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>		CAUSE OF DEATH (A) DUE TO <b>Werdnig Hoffman Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		<b>6 months</b>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the doctor) attended the deceased from <b>10-4-1966</b> to <b>10-7-1966</b> , that (I) (the doctor) last saw the deceased alive on <b>10-7-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (saw) view the body after death.					
23A. SIGNATURE <b>David C. Manger</b>				23B. DATE SIGNED <b>10-7-1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>David C. Manger</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-10-1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOHN J. DUDA, Dundalk, Md. 21222</b>			

THE UNIVERSITY OF CHICAGO

Department of  
Chemistry

John D. MacArthur

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10133	
BIRTH NO. 66 10133		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROBERT BEALE WATKINS		October 5, 1966 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
90 HOUSE IN THE PINES NURSING HOME 2525 W. Belvedere Ave.		Md. A. A. Co.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Rural - Brooklyn Park 52-00			
		D. STREET ADDRESS (If rural, give location)			
		114 W. 8th Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	White	Widowed	June 15, 1889	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clergyman				Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U. S.		James Watkins		Fannie Fogg	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		225-40-7570		Mrs. Lucille Bond - 114 W. 8th Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		Pneumonia	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		Arterio-sclerotic end	
		(C) DUE TO		5 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Sept 5 19 66 to Oct 5 19 66, that (I) (we) last saw the deceased alive on Oct 5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lester N. Koleman				October 5, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Lester N. Koleman				3700 Park Heights Ave., Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Oct. 8, 1966		Forrest Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 10 1966		Robert E. Finkbeiner		George J. Gonce - 4001 Ritchie Hwy.	
				Baltimore, Md. 21225	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10134</u>	
BIRTH NO. <u>66 10134</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED <u>DAVIS, MANIE AGUSTA</u>		2. DATE AND HOUR OF DEATH <u>10/06/66</u>   <u>1:30</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> <u>CATON AND WILKENS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>		A. STATE <u>MARYLAND</u> 21228 B. COUNTY <u>Balts. Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>22 DUNGARRIE ROAD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>5-16-73</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CHEM. CO. RET.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>AGUSTUS DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>MARY MCQUIRE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216 05 1931</u>		17. INFORMANT ADDRESS <u>HOSPITAL SLIP - ST. AGNES HOSPITAL</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Ischemic heart disease</u> DUE TO (B) <u>myocardial infarction</u> DUE TO (C) <u>Renal failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XI</u> (this hospital) attended the deceased from <u>10/04/1966</u> to <u>10/06/1966</u> , that <u>XI</u> (we) last saw the deceased alive on <u>OCTOBER 6, 1966</u> and that in <u>MY</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) <u>XXXX</u> view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>10/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARIN, RAFAEL, M.D.</u>				23D. ADDRESS <u>ST AGNES HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/10/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOUON PARK</u>	
24D. LOCATION <u>BALTO MD</u>		24E. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Fisher</u>	
24G. FUNERAL DIRECTOR <u>55 W. W. ABB</u>		24H. ADDRESS <u>301 FREDERICK RD</u>		24I. CITY, TOWN, OR COUNTY (State) <u>21228</u>	

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BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10135

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Herbert W, Mathias

2. DATE AND HOUR PRONOUNCED DEAD

10/6/66 9:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3616 Hickory Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

May 1, 1940

9. AGE (in years  
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Turn Off Man

10B. KIND OF BUSINESS OR INDUSTRY

Water Dept

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Earl C. Mathias, Jr

14. MOTHER'S MAIDEN NAME

Anne E. Brittingham.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

no

no

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

ADDRESS

Earl C. Mathias. 3616 Roland Ave

18.

E823.4 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Multiple injuries

(A).....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B).....  
DUE TO

(C).....

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CARRYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Jones Falls Expwy. and Falls Rd.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
10 6 66 8:25 p.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger in auto which ran off roadway

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/7/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/10/66

23C. NAME of CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION

(City, town, or county)

(State)

Windsor Mill Rd, Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

VS 151-REV. 1/65

OCT 10 1966 Robert E. Johnson

Austin E. Donovan. 3818 Roland Ave

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10136				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10136	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>KONSTANT MATULIAUSKAS</b>				2. DATE AND HOUR OF DEATH <b>10/8/66 9:54 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4201 EUCLID AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4/13/83</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>==</b>			14. MOTHER'S MAIDEN NAME <b>==</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS WILKENS &amp; CATON AVE.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>FRACTURE - (R) HIP</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>13 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC CONGESTIVE FAILURE</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>9/27/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fr (R) HIP</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner, Body Release, etc.) <b>NOTIFIED</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg.) <b>HOME</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4201 Euclid Ave</b>			
21D. TIME OF INJURY (APPROX.) <b>9/25/66 6 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell when rising from chair to adjust television</b>			
22. I certify that (X) (this hospital) attended the deceased from <b>9/25</b> 19 <b>66</b> to <b>10/8</b> 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>10/8</b> 19 <b>66</b> and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W E Signor M.D.</b>						23B. DATE SIGNED <b>10/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM SIGNOR</b>				23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-11-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Kenny Inc 1600 Hollins St</b>		ADDRESS	

CHARTERED BY THE UNITED STATES OF AMERICA

IN THE YEAR 1864

BY THE SENATE OF THE UNITED STATES

AND BY THE HOUSE OF REPRESENTATIVES

IN SENATE, JANUARY 1864

AND IN HOUSE, FEBRUARY 1864

BY THE SENATE OF THE UNITED STATES

AND BY THE HOUSE OF REPRESENTATIVES

IN SENATE, JANUARY 1864

AND IN HOUSE, FEBRUARY 1864

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BY THE SENATE OF THE UNITED STATES

AND BY THE HOUSE OF REPRESENTATIVES

IN SENATE, JANUARY 1864

AND IN HOUSE, FEBRUARY 1864

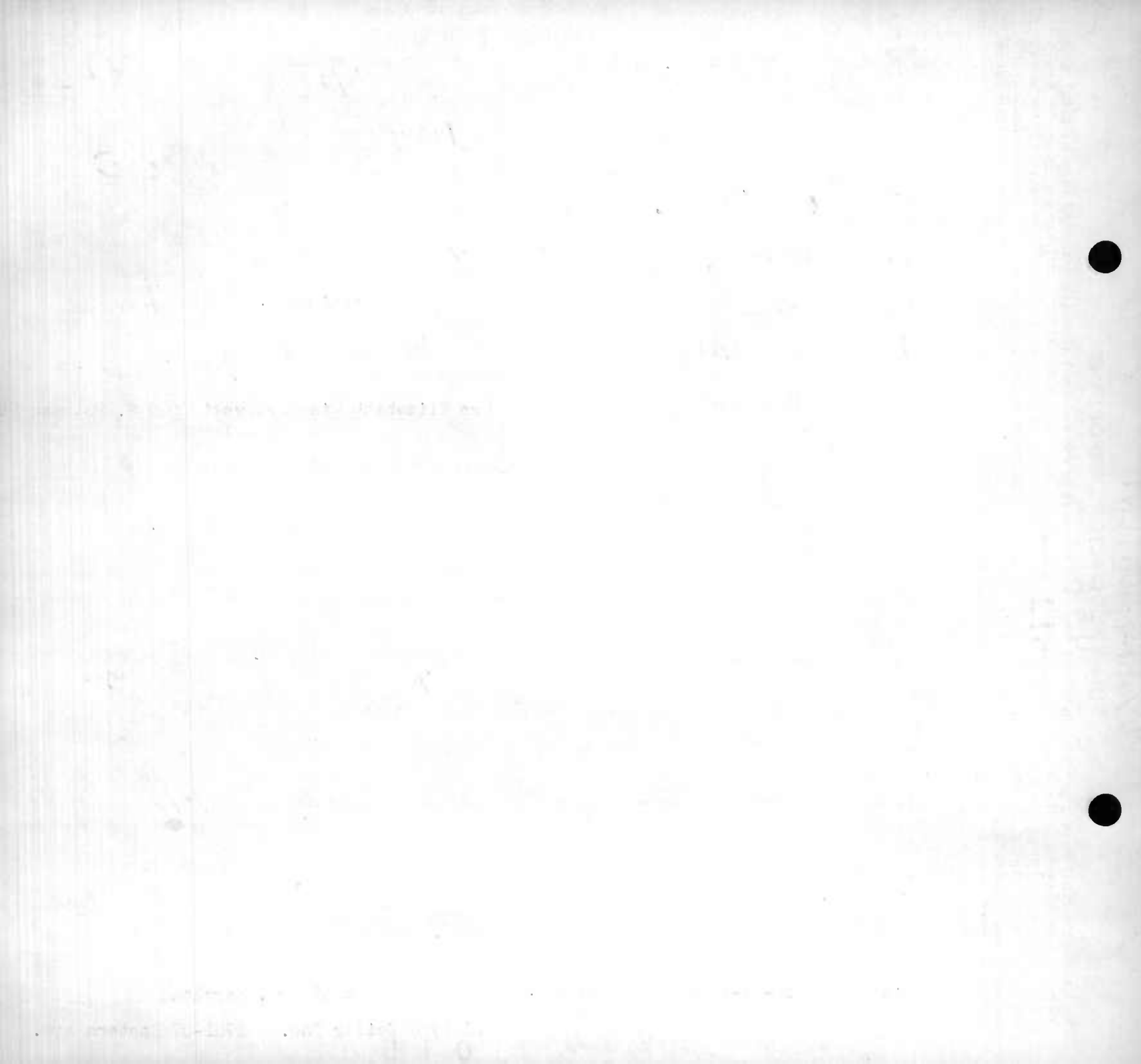
BY THE SENATE OF THE UNITED STATES

FUNERAL DIRECTOR: IMPORTANT

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<p>P-4012</p> <p style="font-size: 24pt; font-weight: bold;">66 10137</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>Registered No. <span style="font-size: 24pt; font-weight: bold;">66 10137</span></p>	
<p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 18pt;">POLSKI, Mrs Barbara</span></p>		<p>2. DATE AND HOUR OF DEATH <span style="font-size: 18pt;">10/7/66</span></p>		<p>8:55 A.M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><span style="font-size: 18pt;">35</span> <span style="font-size: 18pt;">Church home &amp; hospital</span>  <span style="font-size: 18pt;">100 W. Broadway</span>  <span style="font-size: 18pt;">Baltimore, Md 21231</span></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <span style="font-size: 18pt;">Maryland</span></p> <p>B. COUNTY <span style="font-size: 18pt;">Baltimore</span></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 18pt;">6-03</span></p> <p>D. STREET ADDRESS (If rural, give location) <span style="font-size: 18pt;">2128 Orleans St</span></p>			
<p>5. SEX <span style="font-size: 18pt;">Female</span></p>	<p>6. RACE <span style="font-size: 18pt;">White</span></p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 18pt;">widowed</span></p>	<p>8. DATE OF BIRTH <span style="font-size: 18pt;">9.6.91</span></p>	<p>9. AGE (In years last birthday) <span style="font-size: 18pt;">75 yrs</span></p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 18pt;">Home maker</span></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <span style="font-size: 18pt;">Md Baltimore</span></p>	
<p>13. FATHER'S NAME <span style="font-size: 18pt;">Andrew Wilger</span></p>			<p>14. MOTHER'S MAIDEN NAME <span style="font-size: 18pt;">Martha Lang</span></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 18pt;">No</span></p>		<p>16. SOCIAL SECURITY NO. <span style="font-size: 18pt;">Unknown</span></p>		<p>17. INFORMANT ADDRESS <span style="font-size: 18pt;">Mrs Elizabeth Wleczorkowski 630 S. Potomac St</span></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <span style="font-size: 18pt;">Intraventricular and Subarachnoid Hemorrhage</span></p> <p>(A) DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><span style="font-size: 18pt;">10.6.66</span></p> <p><span style="font-size: 18pt;">to 10.7.66</span></p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION <span style="font-size: 18pt;">2</span></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <span style="font-size: 18pt;">Yes</span></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 18pt;">10/6</span> 19 <span style="font-size: 18pt;">66</span> to <span style="font-size: 18pt;">10/7</span> 19 <span style="font-size: 18pt;">66</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 18pt;">10/7</span> 19 <span style="font-size: 18pt;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <span style="font-size: 18pt;">Francisco Baltazar Jr.</span> M.D.</p>				<p>23B. DATE SIGNED <span style="font-size: 18pt;">10/7/66</span></p>	
<p>23C. PHYSICIAN'S NAME (Type) <span style="font-size: 18pt;">FRANCISCO BALTAZAR, JR.</span> M.D.</p>				<p>23D. ADDRESS <span style="font-size: 18pt;">Church Home &amp; Hosp.</span></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 18pt;">Burial</span></p>		<p>24B. DATE <span style="font-size: 18pt;">10-11-1966</span></p>		<p>24C. NAME of CEMETERY or CREMATORY <span style="font-size: 18pt;">Holy Redeemer</span></p>	
<p>24D. LOCATION (City, town, or county) (State) <span style="font-size: 18pt;">Baltimore, Maryland</span></p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p>			
<p>25B. NAME OF REGISTRAR</p>		<p>25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 18pt;">Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</span></p>			





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10138</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>W-406</p> <p>66 10138</p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> </div>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				(Type or Print) <u>Mary C. Wiley</u>	
2. DATE AND HOUR OF DEATH		<u>October 7, 1966</u> <u>11:05</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21224</u>		D. STREET ADDRESS (If rural, give location) <u>3904 Foster Ave.</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
<u>F</u>	<u>W</u>	<u>Never married</u>	<u>12/10/87</u>	<u>78</u>	<u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>None</u>				<u>Maryland</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<u>Thomas H. Wiley</u>			<u>Mary B. Nietzel</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<u>No</u>		<u>00-5042A</u>		<u>Catherine Wiley</u> <u>(Niece)</u> <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the made of heart failure, asthenia, etc. It means injury or complication which caused death.) <u>Fracture of hip</u>		(A) <u>Cerebrovascular Insufficiency</u> DUE TO <u>6 mo</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if giving rise to the above cause (A) including UNDERLYING CONDITION last.		(B) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO <u>30 years</u>			
II OTHER SIGNIFICANT CONDITION CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.		(C) <u>Fracture of hip</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>Sept. 16, 1966</u>		<u>Fractured hip</u>		<u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>		<u>Not determined</u>		<u>not determined</u>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 13</u> 19 <u>66</u> to <u>Oct. 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>W. Michael Gould</u> M.D.				<u>10/7/66</u> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>Burial</u>		<u>10-10-1966</u>		<u>Mt. Carmel</u>	
24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.			
<u>Baltimore, Maryland</u>		<u>OCT 10 1966</u>			
25A. NAME OF REGISTRAR		25B. FUNERAL DIRECTOR		25C. ADDRESS	
<u>Lilly &amp; Zeiler Inc.</u>		<u>1901-07 Eastern Ave.</u>			

Mayland General Hospital

Mayland  
Baltimore  
3804 Foster Ave

F W W

12/1/78

Name

Thomas H. Wiley

May & West

No

12/1/78

12/1/78

12/1/78

12/1/78

12/1/78

No

12/1/78

12/1/78

12/1/78

12/1/78

No

12/1/78

M.E. CASE NO.  
1. NAME OF DECEASED (Type or Print) EDWIN SMITH  
2. DATE AND HOUR PRONOUNCED DEAD October 5, 1966 9:27 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
Provident Hospital  
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland  
B. COUNTY 13-02  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore  
D. STREET ADDRESS (If rural, give location)  
2353 Eutaw Place

5. SEX Male  
6. RACE Colored  
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single  
8. DATE OF BIRTH 8/23/66  
9. AGE (In years last birthday) 12  
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.  
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none  
10B. KIND OF BUSINESS OR INDUSTRY none  
11. BIRTHPLACE (State or foreign country) Md.  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Powell  
14. MOTHER'S MAIDEN NAME Ruth Smith  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no  
16. SOCIAL SECURITY NO. none  
17. INFORMANT ADDRESS Edward Powell 2353 Eutaw Pl

18. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
Interstitital Pneumonitis (SDII)  
DUE TO  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20A. AUTOPSY? (Yes or No) Yes  
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  
21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK  
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.  
CHIEF MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAMINER  
ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 10/5/66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial  
23B. DATE 10/10/66  
23C. NAME OF CEMETERY or CREMATORY Mt. Auburn  
23D. LOCATION (City, town, or county) (State) Balto. Md.

24A. DATE REC'D BY HEALTH DEPT. OCT 10 1966  
24B. NAME OF REGISTRAR R. E. Fairbank  
24C. FUNERAL DIRECTOR Wm. J. Schatman  
ADDRESS 1701 W. Calhoun Balto. Md.

VS 151-REV. 11/7/65

TO : [illegible]  
FROM : [illegible]  
SUBJECT : [illegible]

DATE : [illegible]  
PAGE : [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10140		REGISTERED NO. 66 10140	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>CLARK, LUTHER R.</b>				2. DATE AND HOUR OF DEATH <b>10-5-66 4:30A</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1933 BRADY AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>SINGLE</b>	8. DATE OF BIRTH <b>1 3 1900</b>	9. AGE (In years lost in day) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>County Roads</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Frank P. Clark</b>				14. MOTHER'S MAIDEN NAME <b>Nettie F. Litz</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212126137</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS - CATON &amp; WILKENS AVES</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>153.3 I</b> <b>Generalized Peritonitis</b> <b>Septicemia</b> <b>Perforated Carcinoma of the Sigmoid Colon</b>				INTERVAL BETWEEN ONSET AND DEATH <b>29</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 28</b> 19 <b>66</b> to <b>OCTOBER 5</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 5</b> , 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Pablo P. De Bois</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct. 5, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>PABLO DE BOIS</b>				23D. ADDRESS <b>CATON AND WILKENS AVE. BALTO MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10 8 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Mc Cully</b>		ADDRESS <b>130 E. Fort Ave.</b>	

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66 10141

BALTIMORE CITY HEALTH DEPARTMENT

66 10141  
Registered No.

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rosie Boswell

2. DATE OF DEATH

Oct. 7, 1966 10:15 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND  
FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Provident Hospital  
1514 Division St.  
Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1606 Vincent Ct.

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Oct. 6, 1880

9. AGE (In years  
last birthday)

86

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Reid

14. MOTHER'S MAIDEN NAME

Harriet ?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Sarah Bright Brooklyn, N.Y.

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Anemia

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

(B) Dehydration DUE TO

(C) Senility and Heart Disease

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐NO ☒21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9:00 p.m., Oct. 7, 1966 to 10:15 p.m. Oct. 7, 1966, that (I) (we) last saw the deceased alive on Oct. 7, 1966

and that in (my) (our) opinion death occurred at \_\_\_\_\_ m. from the causes and on the date stated above.

23A. SIGNATURE

Ata Amin

M. D.

23B. ADDRESS

1514 Division St.

23C. DATE SIGNED

10-7-66

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/10/66

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 10 1966

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

W.I. Chatman, Jr. 1701 McCulloh St.

ADDRESS

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THIS IS A PERMANENT RECORD.  
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

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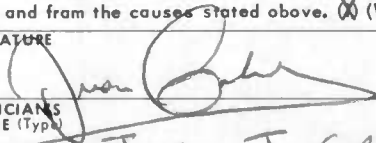
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10142</u>	
BIRTH NO. <u>66 10142</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>XXXXXXXXXX ISABEL M. LYON</u>		2. DATE AND HOUR OF DEATH <u>OCTOBER 4, 1966</u>   <u>7:35 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> <u>CATON AND WILKE NS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>21229</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE,</u>			
		D. STREET ADDRESS (If rural, give location) <u>VENTNOR LODGE-526 S. CHAPELGATE</u> <u>La</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>SINGLE</u>	8. DATE OF BIRTH <u>10-02-80</u>	9. AGE (In years lost birth day) <u>86</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>WM. A. LYON (DECEASED)</u>			14. MOTHER'S MAIDEN NAME <u>ISABEL MAY SCHERER (DECEASED)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>HOSPITAL SLIP -ST.AGNES HOSPITAL</u>	
18. <u>290.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE ANTERIOR MYOCARDIAL INFARCTION</u> (A) DUE TO		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>PERNICIOUS ANEMIA</u>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 2, 1966</u> to <u>OCTOBER 4, 1966</u> , that (X) (we) last saw the deceased alive on <u>OCTOBER 4, 1966</u> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) (not) view the body after death.					
23A. SIGNATURE  JUAN T. CABRERA M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/7/66</u>		24C. NAME of CEMETERY or CREMATORY <u>GREENMOUNT CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Isabel M. Lyons</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. MEARS &amp; SON 805 N. CALVERT ST.</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 10143		BALTIMORE CITY HEALTH DEPARTMENT		X		Registered No. 66-10143	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>John C. Murray</b>				2. DATE AND HOUR OF DEATH <b>Oct. 9, 1966</b> <b>1:00 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Balto. Co.</b>					
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>53-00</b>					
D. STREET ADDRESS (If rural, give location) <b>216 Hopkins Rd.</b>									
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>		8. DATE OF BIRTH <b>5/1/93</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce Merchant</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John C. Murray</b>				14. MOTHER'S MAIDEN NAME <b>Keady, Mary</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW I</b>				16. SOCIAL SECURITY NO. <b>220-30-1049</b>		17. INFORMANT <b>chart</b>		ADDRESS	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of colon</b>				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>07/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer</b>		20A. AUTOPSY (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 26, 1966</b> to <b>Oct. 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct. 9, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Arthur M. Morris</b> M.D.				23B. DATE SIGNED <b>10/9/66</b>					
23C. PHYSICIAN'S NAME (Type) <b>Arthur M. Morris</b>				23D. ADDRESS <b>Maryland General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Green Mount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd., Baltimore, Md. 21212</b>			



47-82-173  
NITW

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

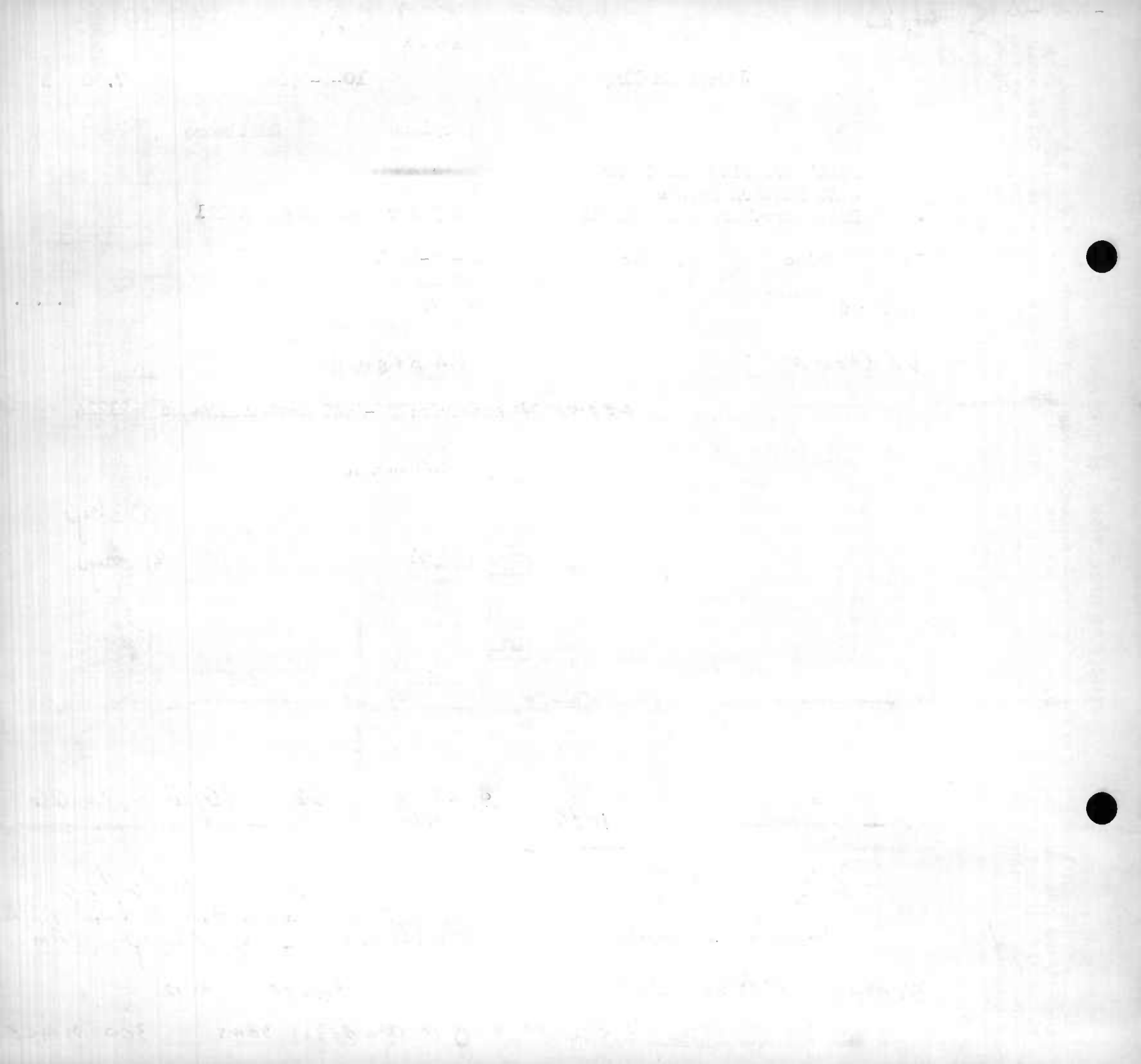
Baltimore City Health Department				Registered No. 66 10144	
BIRTH NO. 66 10144				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>HARRY Hoyer</u>	
2. DATE AND HOUR OF DEATH <u>10-5-66</u> <u>4:01</u> <u>P</u> M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
6. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				7. STREET ADDRESS (If rural, give location) <u>219 WEST ROAD - 21221</u>	
8. SEX <u>FEMALE</u>				9. RACE <u>WHITE</u>	
10. MARRIED, NEVER MARRIED <u>MARRIED</u>				11. DATE OF BIRTH <u>8/15/19</u> <u>1918</u>	
12. AGE (In years last birthday) <u>47</u> <u>48</u>				13. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				15. KIND OF BUSINESS OR INDUSTRY	
16. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>				17. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. FATHER'S NAME <u>PETER PASTUSIC</u>				19. MOTHER'S MAIDEN NAME <u>JOSEPHINE -- Sofia Say</u>	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				21. SOCIAL SECURITY NO. <u>205-05-9845</u>	
22. INFORMANT <u>RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224</u>				23. ADDRESS	
24. CAUSE OF DEATH				25. INTERVAL BETWEEN ONSET AND DEATH	
26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				27. (A) <u>Subarachnoid hemorrhage</u>	
28. ANTECEDENT CAUSES				29. (B) DUE TO	
30. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				31. (C)	
32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				33. <u>Hypertension</u> <u>20 yrs.</u>	
34. DATE OF OPERATION				35. CONDITION FOR WHICH OPERATION WAS PERFORMED	
36. AUTOPSY? (Yes or No) <u>NO</u>				37. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
38. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)				39. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
40. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				41. HOW DID INJURY OCCUR?	
42. TIME OF INJURY (Approx.)				43. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
44. I certify that (1) (this hospital) attended the deceased from <u>10-1</u> <u>1966</u> to <u>10-5</u> <u>1966</u> , that (2) (we) last saw the deceased alive on <u>10-5</u> <u>1966</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
45. SIGNATURE <u>Richard L. Bishop</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				46. DATE SIGNED <u>10-5-66</u>	
47. PHYSICIAN'S NAME (Type) <u>RICHARD L. BISHOP</u>				48. ADDRESS <u>BALTIMORE CITY HOSPITALS</u>	
49. ADDRESS <u>4940 Eastern Avenue, Balto. Md. 21224</u>				50. LOCATION (City, town, or county) (State)	
51. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>				52. DATE <u>10/8/66</u>	
53. NAME OF CEMETERY or CREMATORY <u>Meadowridge</u>				54. LOCATION <u>Balto. Md</u>	
55. DATE REC'D BY HEALTH DEPT.				56. NAME OF REGISTRAR	
57. FUNERAL DIRECTOR <u>JOHN J. KELLY Sons</u>				58. ADDRESS <u>300 Main</u>	



Birth Cert. from Penna. of Decedent  
10-20-66 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>400</b>		66 10145		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 10145</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Joseph Szallay</b>				2. DATE AND HOUR OF DEATH <b>10-6-1966</b>		7.30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>Balt. Co.</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>53-00</b>			
				D. STREET ADDRESS (If rural, give location) <b>315 Savannah Road 21221</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widower</b>	8. DATE OF BIRTH <b>12-24-1882</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>283-01-5485</b>		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue</b>		ADDRESS <b>21224</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>CVA</b>		<b>14 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>9/22</b> <b>1966</b> to <b>10/6</b> <b>1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>10/6</b> <b>1966</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.							
23A. SIGNATURE <b>Phillip L. Hall</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/6/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>PHILLIP L. HALL</b>				23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland</b> <b>Baltimore City Hosp. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/8/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>ZION</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>P. B. E. Fisher</b>		25C. FUNERAL DIRECTOR <b>J. G. O'NEILL SONS</b>		ADDRESS <b>300 MACE</b>	



66 10146

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 66 10146

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Raley, Daniel R

2. DATE AND HOUR OF DEATH

11:10 PM 10/5/66

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

27-18

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4903 Danmore Ave #21215

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

3/9/90

9. AGE (In years  
last birthday)

76

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOSEPH

M. Raley

14. MOTHER'S MAIDEN NAME

MARY ANN

Dorsey

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-10-2887

17. INFORMANT

RECORDS:

ADDRESS

BCH 4940 EASTERN AVE. BALTO., MD. #21224

18. 153.8 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

respiratory arrest

INTERVAL BETWEEN  
ONSET AND DEATH

10 min.

(B) DUE TO

Probable disseminated carcinoma  
of the colon

4 yrs.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 9-30 1966 to 10/5 1966,  
that (1) (we) lost saw the deceased alive on 10/5 1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C.P. Wilkinson

M.D.

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

10/5/66

23C. PHYSICIAN'S  
NAME (Type)

C.P. Wilkinson

M.D.

23D. ADDRESS

4940 EASTERN AVE. BALTIMORE, MD. #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/10/66

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge

24D. LOCATION

(City, town, or county) (State)

Pikesville 21208

Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Loring Byers-8728 Liberty Rd. Randallstown

OCT 10 1966

30159

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10147		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10147	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Dixon M. Crawford		2. DATE AND HOUR OF DEATH October 6, 1966		2:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital 43		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 30 D. STREET ADDRESS (If rural, give location) 1744 Webster Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 16, 1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAMAN		10B. KIND OF BUSINESS OR INDUSTRY B.O.P.R.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Dixon M Crawford (deceased)		14. MOTHER'S MAIDEN NAME Jenny Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn Crawford (wife)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) E900.0 SUBDURAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Subdural Hemorrhage DUE TO Skull Fracture (B) DUE TO (C) Pulmonary Empyema Stress Gastric Ulcer due to		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION Sept. 8, 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hemorrhage		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1744 Webster Street, Baltimore 30, Md.	
21D. TIME OF INJURY (APPROX.) Sept. 8, 1966 7PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Patient fell off their stairs at home.	
22. I certify that (I) (this hospital) attended the deceased from September 6 1966 to October 6 1966, that (I) (we) last saw the deceased alive on October 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Consolador C. Palad, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 6, 1966	
23C. PHYSICIAN'S NAME (Type) Consolador C. Palad, Jr.		23D. ADDRESS M.D. South Baltimore General Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) B		24B. DATE 10/8/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore		24E. DATE REC'D BY HEALTH DEPT. OCT 10 1966			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR K. E. Taylor		24H. ADDRESS 130 E. Fair Ave.	

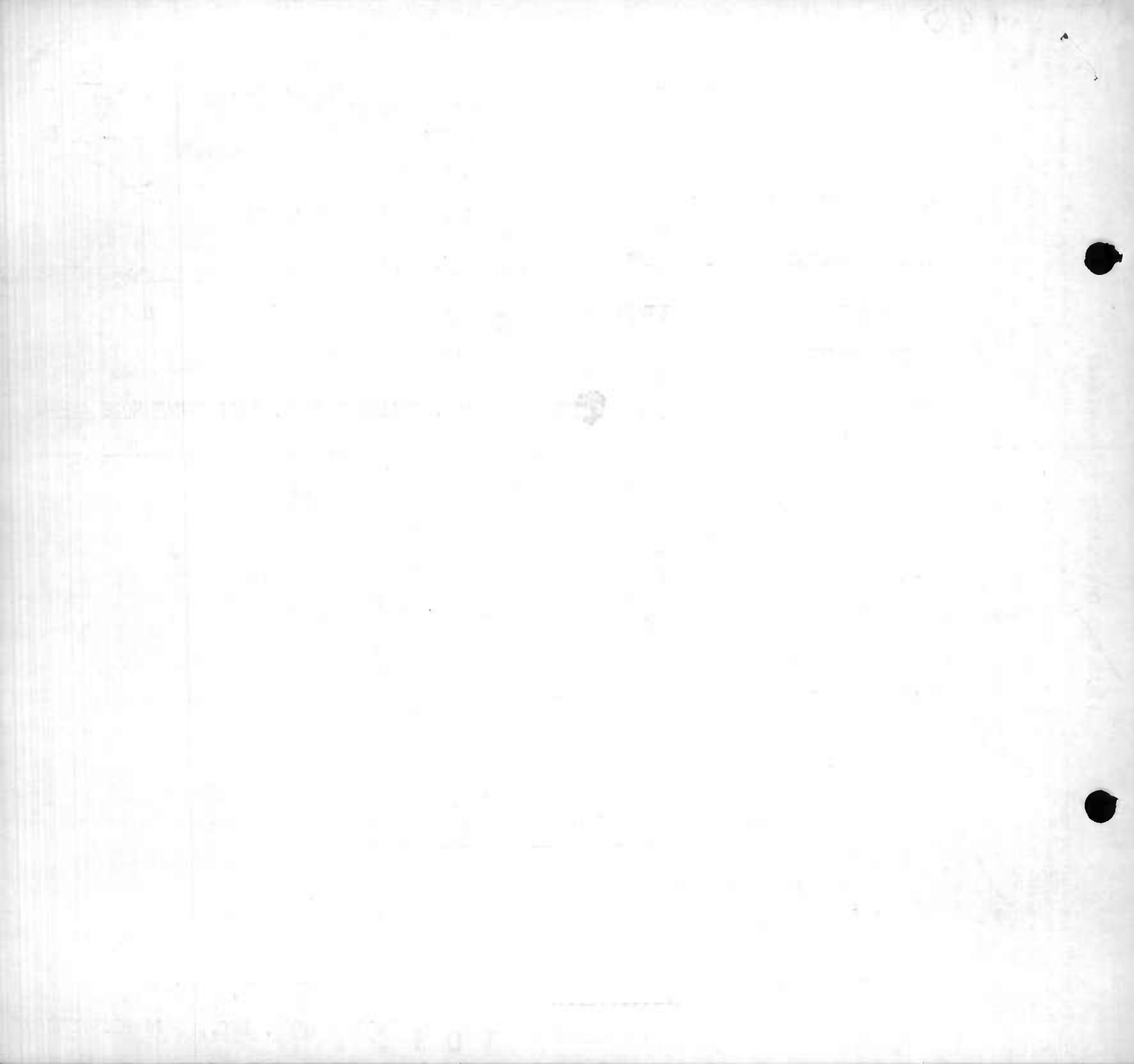
*[Handwritten signature]*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

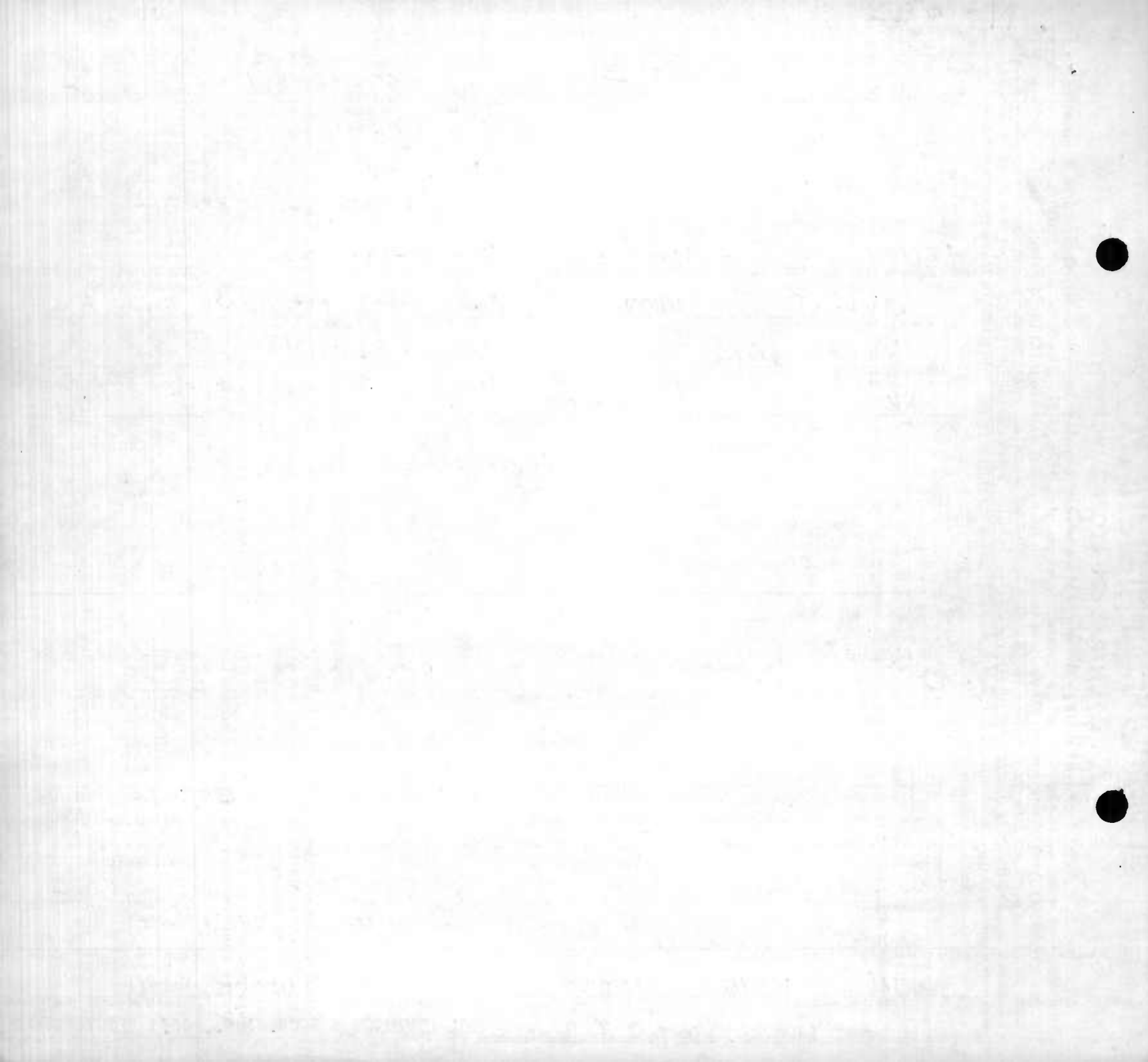
BALTIMORE CITY HEALTH DEPARTMENT									
66 10148					Registered No. 66 10148				
BIRTH NO. 66 10148					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>Sol SHOFER</b>					2. DATE AND HOUR OF DEATH <b>10/6/66 12:22 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-20</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>3901 STRATHMORE AVENUE</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB 7, 1907</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days Hours		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>HENRY SHOFER</b>			14. MOTHER'S MAIDEN NAME <b>LENA ?</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MRS. MOLLYE SHOFER, 3901 STRATHMORE AVENUE</b>				ADDRESS
18. <b>420.141260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Ant. Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ISCVD</b>					CAUSE OF DEATH (A) <b>ISCVD</b> (B) <b>ISCVD</b> (C) <b>ISCVD</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes mellitus</b>									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12/64</b> 19 to <b>10/6/66</b> 19, that (I) (we) last saw the deceased alive on <b>10/1/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Joseph Shearman</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH SHEARMAN</b>					23D. ADDRESS <b>675 Park Heights Baltimore Md</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/9/66</b>		24C. NAME of CEMETERY or CREMATORY <b>ANSHE EMUNAH AITZ CHAIN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

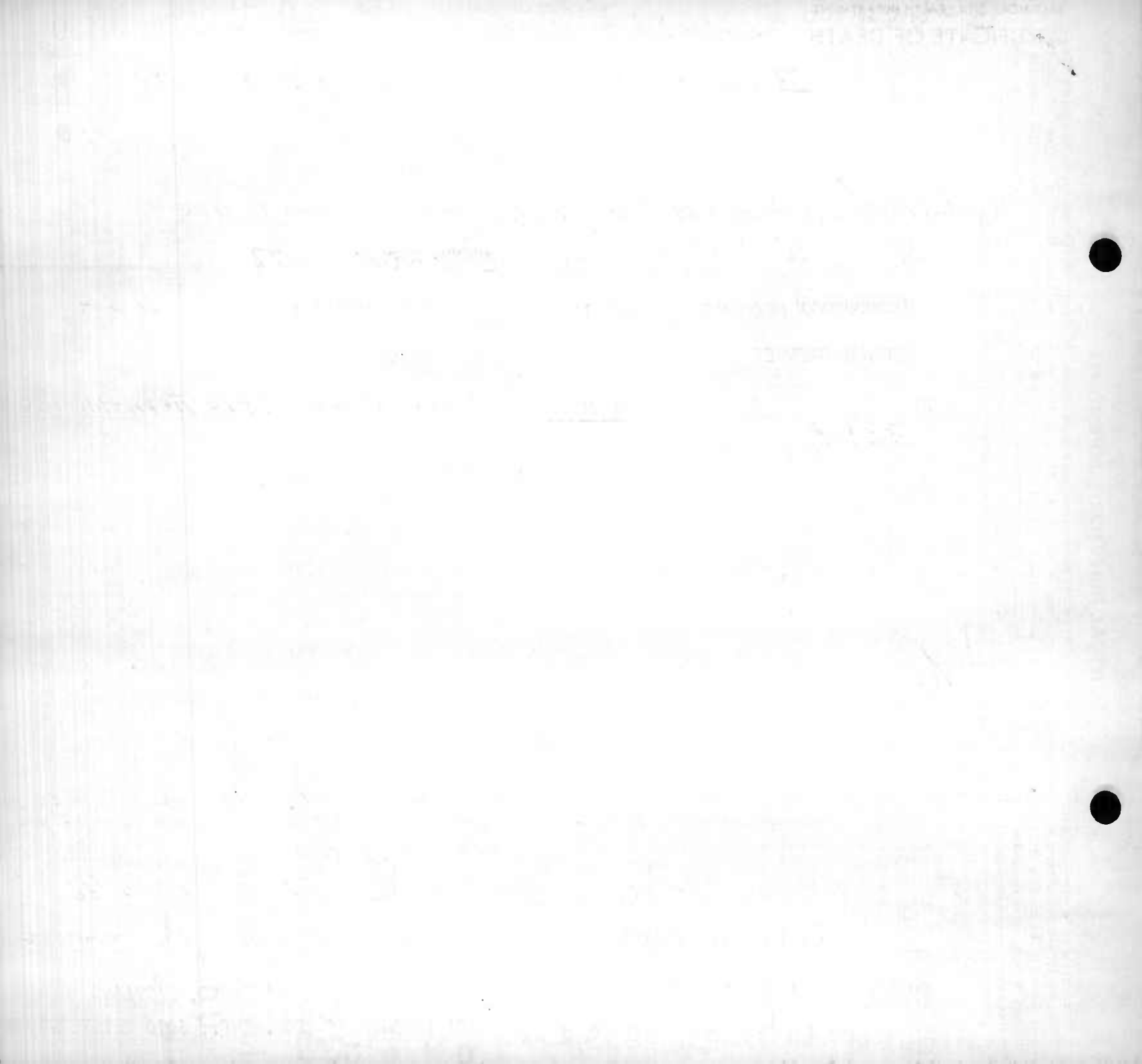
BIRTH NO. 66 10149		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10149	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOAN NORWITZ		2. DATE AND HOUR OF DEATH OCTOBER 6, 1966 9:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 5524 NORTHGREEN Rd. #7	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH APRIL 11, 1944	9. AGE (In years last birthday) 22	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NORMAN NORWITZ		14. MOTHER'S MAIDEN NAME ESTHER LEVIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT NORMAN NORWITZ - FATHER	
18. 204.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE GRANULOCYTIC LEUKEMIA DUE TO		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 15, 1966 to OCTOBER 6, 1966, that (I) (we) last saw the deceased alive on OCTOBER 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco D. Sabado, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Oct. 6, 1966	
23C. PHYSICIAN'S NAME (Type) FRANCISCO D. SABADO, JR.		M.D. 23D. ADDRESS SINAI HOSP. OF BALTIMORE BALTIMORE, MARYLAND 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/9/66		24C. NAME OF CEMETERY or CREMATORY FARBAND	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-656 66 10150				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10150	
CERTIFICATE OF DEATH							
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Bronner, Samuel</i>				2. DATE AND HOUR OF DEATH <i>4:10 p.m. 9/4/66</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hosp. of Maryland</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>15-10</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>3810 Fernhill Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>XXXXXXXXXX</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>XXXXXXXXXX</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>RETAIL</i>		11. BIRTHPLACE (State or foreign country) <i>SOUTH CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ABRAHAM BRONNER</i>				14. MOTHER'S MAIDEN NAME <i>HANNA ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>Wife, Dora. 3810 Fernhill Ave.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>331 X I</i>				CAUSE OF DEATH (A) <i>CVA</i>		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 24. 1966</i> to <i>Oct. 4. 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct. 2. at 3:00 p.m. 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Wonja Kim</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/4/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>WON JA KIM</i>				23D. ADDRESS <i>Lutheran Hosp. in Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/5/66</i>		24C. NAME of CEMETERY or CREMATORY <i>OHR KNESSETH ISRAEL ANSHE SEARD</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</i>			

OCT 10 1966

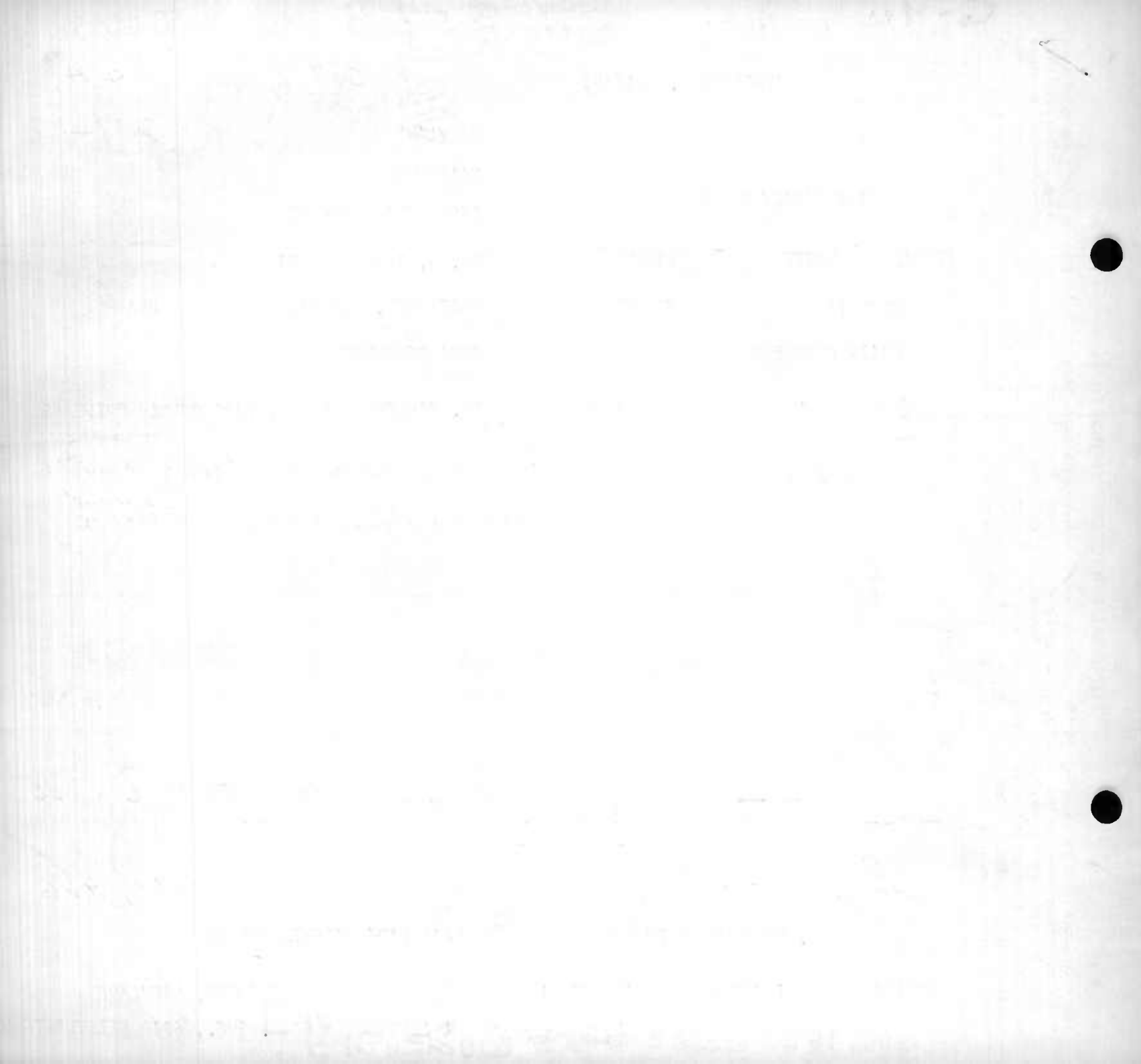


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 10151		CERTIFICATE OF DEATH				Registered No. 66 10151			
1. NAME OF DECEASED (Type or Print) KATHERINE G. GELFAND					2. DATE AND HOUR OF DEATH Oct 6, 1966 4:17 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-17				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2906 OAKLEY AVENUE					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 2906 OAKLEY AVENUE				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH FEB. 5, 1895	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME PHILIP GOLDBERG					14. MOTHER'S MAIDEN NAME ANNA ROSENBERG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS MR. RAYMOND GELFAND, 7402 DORMAN DRIVE #8				
18. CAUSE OF DEATH 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION DUE TO CORONARY ATHEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 5 minutes Several years									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 1961 to Oct 6 1966, that (I) (we) last saw the deceased alive on Sept 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Seymour H Rubin					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED Oct 6, 1966	
23C. PHYSICIAN'S NAME (Type) DR. SEYMOUR RUBIN					23D. ADDRESS 5415 PARK HEIGHTS AVENUE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/9/66		24C. NAME OF CEMETERY or CREMATORY BNAT ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10152				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10152	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) <b>NAPOLEON HENDERSON</b>						<b>OCT. 8, 1966 10:10 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<b>46 LUTHERAN HOSPITAL OF MARYLAND</b>				<b>MARYLAND</b>		<b>CATONSVILLE Balt. Co.</b>	
5. SEX <b>MALE</b>				6. RACE <b>COLORED</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SEPARATED</b>	
8. DATE OF BIRTH <b>MARCH 23, 1900</b>				9. AGE (in years last birthday) <b>66</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Joseph Henderson</b>			
14. MOTHER'S MAIDEN NAME <b>Rebecca Rideout</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <b>Mrs Patsy H Boone 8, Jones Ave</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				<b>Aspiration pneumonia</b>			
ANTECEDENT CAUSES				<b>SPINAL CORD INJURY</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>Heart failure</b>			
II				INTERVAL BETWEEN ONSET AND DEATH <b>CS</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>8 Jones Ave 53-00</b>			
21D. TIME OF INJURY (APPROX.) <b>9/23/66 10:00 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell down stairs at home</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 23 1966</b> to <b>Oct. 8 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct. 8 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jose V. de Leon, Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct. 8, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE V. DE LEON, JR.</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON ST., BALTIMORE, MARYLAND</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>1206 W North Ave</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10153		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 10153	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ELIZABETH GILLYARD (Gaillard)</b>		2. DATE AND HOUR OF DEATH <b>October 7, 1966</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1125 Webb Court</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1125 Webb Court</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1/4/90</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months; Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Old Age</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Goose Creek S Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Paul Pointer</b>			14. MOTHER'S MAIDEN NAME <b>Mary</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-54-3384</b>	17. INFORMANT ADDRESS <b>Mrs Sarah L Ford 1125 Webb Court</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>443 X</b> <b>INTERVENTIVE CARDIOVASCULAR DISEASE</b> <b>ASTHMA (BRONCHIAL)</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/1/66</b> to <b>10/7/66</b> and that (I) (we) last saw the deceased alive on <b>10/1/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Garner</b>				23B. DATE SIGNED <b>10/2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. GARNER</b>				23D. ADDRESS <b>1005 W Lafayette Ave Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>			
25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1206 W North Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10154				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10154	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Isaac B. Freeland				October 6, 1966 8:05 a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital 1514 Division Street Baltimore, Maryland 21217				Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				1302 Laurens Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Male	Negro	Widowed	May 5, 1899	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Gas & Electric Co		Calvert County, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		218-10-7544		James B. Kent-son		Sunderland, Calvert County, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)				(A) Moderate generalized arterio-sclerosis			
ANTECEDENT CAUSES				(B) Decubital ulcers of buttock and heel			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Meningioma of left occipital fossa			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from September 25, 19 66 to October 6, 19 66, that (I) (we) last saw the deceased alive on October 6, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. C. Laredo						October 7, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. C. Laredo				1514 Division Street-Baltimore 17, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/10/66		Mt. Auburn Cemetery		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 10 1966		Adolphus Halstead		Adolphus Halstead		1206 W North Ave	

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 10155					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 10155				
1. NAME OF DECEASED (Type or Print) <b>FLOWERS, MARY CATHERINE</b>					2. DATE AND HOUR OF DEATH <b>OCTOBER 7, 1966 12:00P.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission), A. STATE <b>MARYLAND</b> B. COUNTY <b>Balt. Co</b>				
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL WILKENS AVES. BALTIMORE, MD. 21229</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b>				
D. STREET ADDRESS (If rural, give location) <b>1506 INGLESIDE AVE. 21207</b>									
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>9-3-92</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES E. RIDGELY</b>					14. MOTHER'S MAIDEN NAME <b>FANNIE GOODMAN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE</b>					16. SOCIAL SECURITY NO. <b>NONE</b>				
17. INFORMANT <b>MRS. HILDA E. BUSCHMAN, SAME AS 4d#2</b>					ADDRESS <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.1 + I E 704.1</b> (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Arteriosclerotic Heart Disease</b>				
INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Fracture of Femur Surgery for Fracture of Femur</b>									
19A. DATE OF OPERATION <b>10/6/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture of Femur</b>			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>St Agnes Hospital</b>			
21D. TIME OF INJURY (APPROX.) <b>10 4 1966 8pm</b>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? <b>Fell in the Bathroom at Hospital</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 24 19 66</b> to <b>OCTOBER 7 19 66</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 7 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Thos J. Mills</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>10/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert E. Farber</b>					23D. ADDRESS <b>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVE</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-11-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE CEMETERY</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>			25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">66 10156</span>				
BIRTH NO. <span style="font-size: 1.2em;">66 10156</span> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BEAUCHAMP, ADA MAY</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">OCTOBER 8, 1966</span> <span style="float: right;">4:25P M.</span>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <div style="display: flex; justify-content: space-between;"> <div>                         FULL NAME OF HOSPITAL OR INSTITUTION   <span style="font-size: 1.5em;">40</span> </div> <div>                         (If not in hospital or institution, give street address or location)   <span style="font-size: 1.2em;">ST. AGNES HOSPITAL</span> </div> </div>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.5em;">28-04</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4702 SAYER AVE. APT 1 21229</span>				
5. SEX <span style="font-size: 1.2em;">FEMALE</span>		6. RACE <span style="font-size: 1.2em;">WHITE</span>		7. MARRIED, NEVER MARRIED <span style="font-size: 1.2em;">WIDOW</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">10-13-82 85</span>		9. AGE (In years lost day) <span style="font-size: 1.2em;">83-80</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">NONE</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">NONE</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">LOUIS Boughman</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">UNKNOWN Mary V. Zeigler</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NONE</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-48-0261</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. Geneva Taylor-4702 Sayer Av. ST. AGNES HOSPITAL RECORDS</span>				
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                         DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                          (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                           ANTECEDENT CAUSES                          DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                     </div> <div style="width: 50%;">                         (A) <span style="font-size: 1.5em;">Acute Pulmonary Edema</span>                          DUE TO                          (B) <span style="font-size: 1.5em;">Myocardial Infarction</span>                          DUE TO                          (C) <span style="font-size: 1.5em;">Coronary Thrombosis</span> </div> </div>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">OCTOBER 8, 1966</span> to <span style="font-size: 1.2em;">OCTOBER 8, 1966</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">OCTOBER 8, 1966</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.5em;">P. Dibos</span>					M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <span style="font-size: 1.2em;">10/8/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">P. DIBOS, M.D.</span>					23D. ADDRESS <span style="font-size: 1.2em;">ST. AGNES HOSP; CATON &amp; WILKENS AVES. #29</span>				
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10-11-66</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Loudon Park Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 10 1966</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley, MA</span>			25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Witzke F.D. - 4101 Edmondson Ave.</span>			

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66 10157

BALTIMORE CITY HEALTH DEPARTMENT

66 10157

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Theodore R. Bond

2. DATE AND HOUR PRONOUNCED DEAD

10/6/66 6:30 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

43

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

867 Bethune Rd

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

separated

8. DATE OF BIRTH

Aug 9, 1939

9. AGE (In years  
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bertie Co. N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lucille Bond

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-349119

17. INFORMANT

ADDRESS

Lucille Bond 637 W. Lafayette Ave

18.

E 98-21X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive internal bleeding  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Stab wound of chest, involving aorta  
and lung  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

876 Bethune Rd.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 6 66 6:00 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

stabbed in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/7/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct. 10, 1966

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

Westport (Baltimore)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 10 1966

R. E. &amp; E. Fabela

Joseph L. Bros

222 N. West Ave.  
Baltimore, Md.

WALTER FORD

WALTER FORD  
1910

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10158		CERTIFICATE OF DEATH		Registered No. 66 10158	
1. NAME OF DECEASED (Type or Print) <i>Rebecca Armstrong</i>				2. DATE AND HOUR OF DEATH <i>10/1/66 11:15 P M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Bolton Hill Nurs Home</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>X</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 15-02</i> D. STREET ADDRESS (If rural, give location) <i>1671 BAKBURY CT.</i>					
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>4/18/99</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>S. CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
13. FATHER'S NAME <i>Perstell DUBOSE</i>				14. MOTHER'S MAIDEN NAME <i>Frances MARTIN</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Mrs Willie Mae Waters</i>		ADDRESS <i>2111 Garrison Blvd</i>			
18. <i>331X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>cerebro-vascular accident</i> DUE TO (B) <i>cerebral arteriosclerosis</i> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>  <i>several yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>rheumatoid arthritis</i>				<i>several months</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>4-12-1966</i> to <i>Oct 1, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept. 30 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>E Ellsworth Cook</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/1/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>E. ELLSWORTH COOK</i>				23D. ADDRESS M.D. <i>2131 MARYLAND AVE. BALTO 21218 Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 6, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Westport (Baltimore) Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Joseph E. Ruse</i>		ADDRESS <i>2222 W. Parkway, Baltimore, Md.</i>			



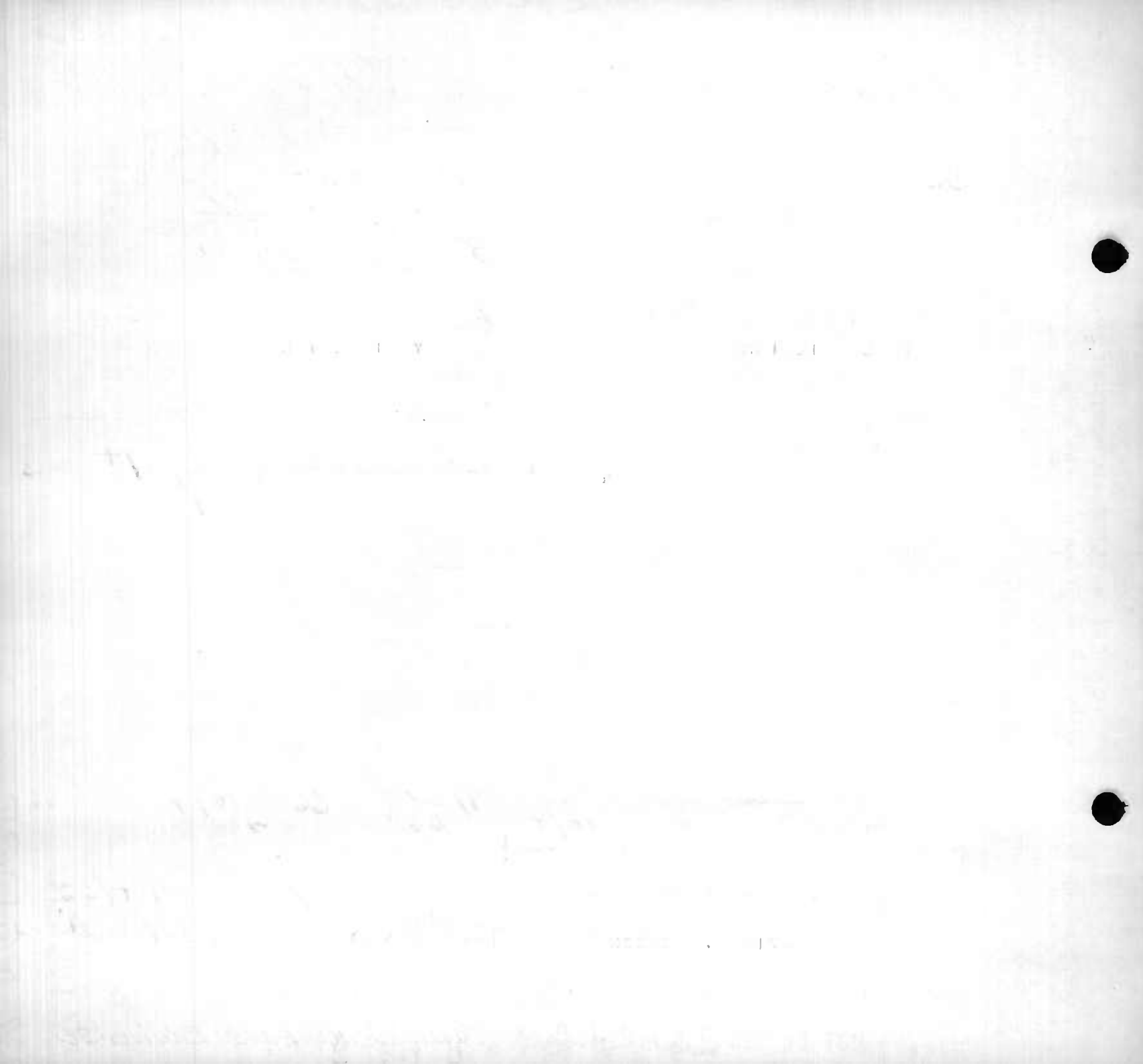


*Handwritten signature or initials.*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10159	
BIRTH NO. 66 10159		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Tillman, Jean</i> or <i>Jennie</i>		2. DATE AND HOUR OF DEATH <i>Oct 4, 1966 @ 1:15 P</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Balto.</i> B. COUNTY <i>md</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns. Hopkins Hosp</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1304 Rose St</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>3/28/27</i>	9. AGE (In years last birthday) <i>39</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>ownhome</i>		11. BIRTHPLACE (State or foreign country) <i>Emporia, Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>ATWELL WILLIAMS</i>		14. MOTHER'S MAIDEN NAME <i>MARY SINGLETON</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Stewart W. Tillman</i> ADDRESS <i>1304 Rose St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>3-9-3X I</i>		CAUSE OF DEATH (A) <i>Chronic renal insufficiency</i> DUE TO (B) <i>—</i> DUE TO (C) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1+ years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>9/28</i> 19 <i>66</i> to <i>10/4</i> 19 <i>66</i> , that (I) ( <del>my</del> ) last saw the deceased alive on <i>10/4</i> 19 <i>66</i> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>my</del> ) (did) ( <del>not</del> ) view the body after death.					
23A. SIGNATURE <i>David S. Fedson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/4/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DAVID S. FEDSON</i>		23D. ADDRESS <i>The Johns Hopkins Hospital Baltimore</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-10-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>National Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
25C. FUNERAL DIRECTOR <i>Randolph J. Collick</i>		25D. ADDRESS <i>2431 E. Oliver St.</i>			



1  
5-530

66 10160

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66-15698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10160

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GREGORY M. SMITH, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

October 5, 1966 12:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4101 Forrest Park Avenue

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4101 Forrest Park Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 1, 1966

9. AGE (In years  
lost birthday)If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Gregory Smith Sr.

14. MOTHER'S MAIDEN NAME

Kushin Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Gregory Smith Sr. Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial Pneumonitis (SDII)  
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/8/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALTER POLICE

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Walter Police  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10161		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10161	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Smith, Elizabeth</i>		
2. DATE AND HOUR OF DEATH			7 Oct 66 10:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
38 Univ. of Md. Hosp.			Md.		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			Baltimore 16 16-05		
D. STREET ADDRESS (If rural, give location)			2304 Arunah Ave		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	N	married	6/3/14	52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Domestic		South Carolina	USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Sylvester Jones			Tiller Camel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Willie Smith Hosp. records Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
530X1			Brain damage		5 days
ANTECEDENT CAUSES			(B) Ruptured berry aneurysm		5 days
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			None		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2 Oct 1966 to 7 Oct 1966, that (I) (we) last saw the deceased alive on 7 Oct 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Robert A. Negron, M.D.</i>				7 Oct 66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Robert A. Negron				Univ. of Md. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Removal		10/9/66		New Mt. Zion	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 10 1966		Robert E. Farber		Arlington Phillips 1727 N. Mount	

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Robert A. Nelson

Robert A. Nelson

Robert A. Nelson



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN A. WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

October 6, 1966 8:05 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

638 W. Mosher Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

638 W. Mosher Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/13/1907

9. AGE (In years last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Crane operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Williams

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-03-9714

17. INFORMANT

Delores Laws 1723 Westwood Ave

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebellar hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Charles S. Springate

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 6, 1966

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10/10/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

Baltimore

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

OCT 10 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wilmington Phillips 172 N. Main St.

ADDRESS

3/13/1947

Monday

Virginia

Gene Spivey

Washington

Joseph Williams

2103 904 Brown Lane 1723 W.

75



IN COMMENT



Postmark

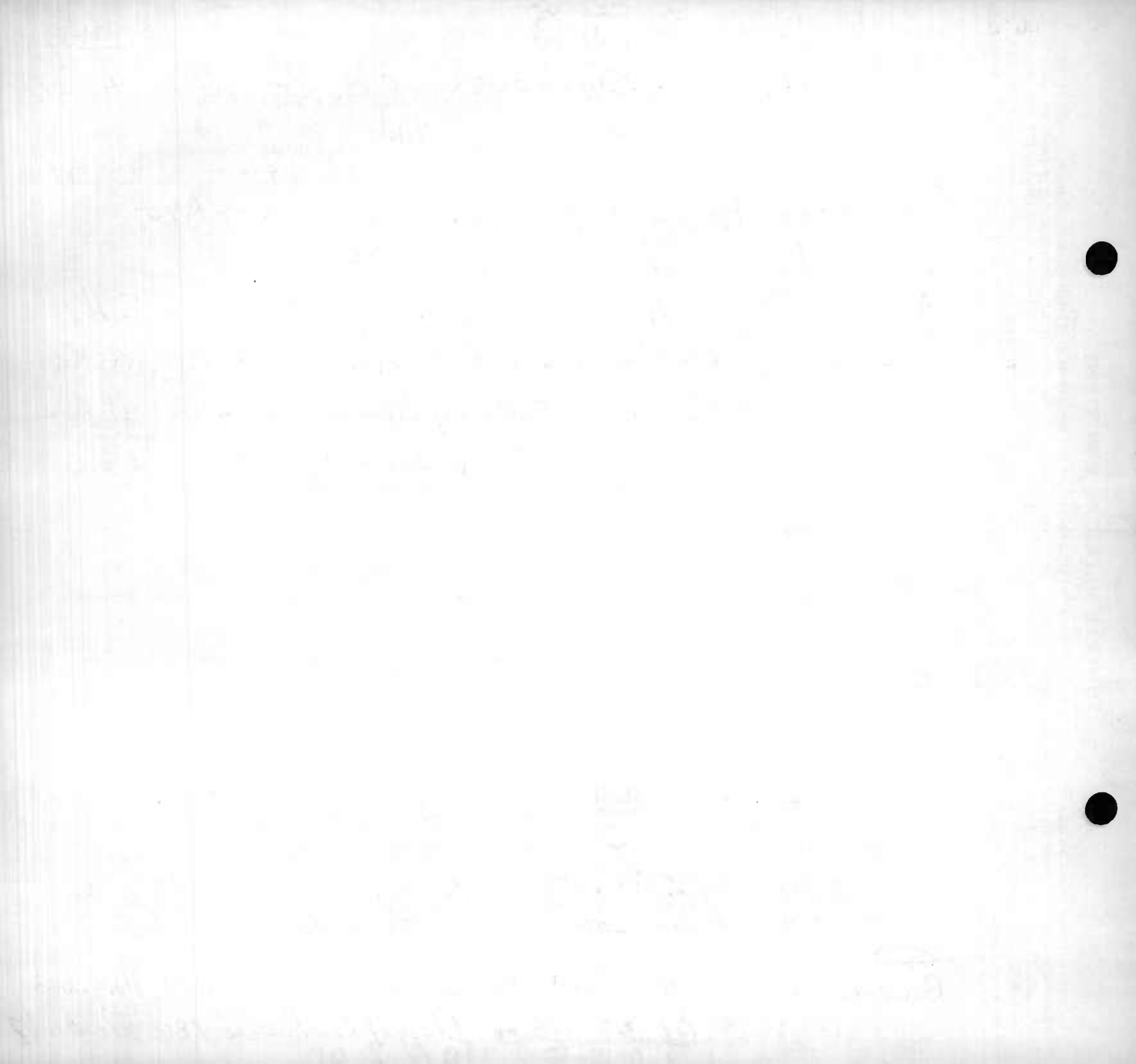
Received 10/11/46 Mt. Vernon

(Unidentified)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 10163					Registered No. 66 10163				
BIRTH NO.					CERTIFICATE OF DEATH				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)				
					Helen K. Swiderski				
2. DATE AND HOUR OF DEATH					Oct. 8 - 1966 4:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
					A. STATE Md.				
FULL NAME OF HOSPITAL OR INSTITUTION					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
(If not in hospital or institution, give street address or location)					Balto. 1-01				
35 Church Home Hosp					D. STREET ADDRESS (If rural, give location)				
					1207 S. Decker Ave				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
K.	W.	Widowed	March 12 1893	73					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY		
At Home			None		Balto. Md.		U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			ADDRESS			
Jacob Graczewski			Katherine ? Hojnaska			22			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				
No			212-10-17290		Mary Kremer 6712 Duluth Ave				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) Arteriosclerotic Cardio-vascular Disease				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
INTERVAL BETWEEN ONSET AND DEATH					5 yrs				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O						NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Aug 1964 to Oct 1966, that (I) (we) last saw the deceased alive on Oct 2 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Clarence W. LeDoux M.D.						10/9/66			
23C. PHYSICIAN'S NAME (Type) CLARENCE W. LEDOUX M.D.						23D. ADDRESS			
						3023 Eastern ave			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town or county) (State)			
Burial		Oct 11-66		Holy Cross Nat. Catholic		German Hill Rd Maryland			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			
OCT 10 1966			Robert E. Fink			Dippel Brothers Inc 1800 E Lombard St			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10164	
BIRTH NO. 66 10164		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LOGAN, JAMUEL</u>		2. DATE AND HOUR OF DEATH <u>10/7/66 8:50 AM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY Hospital</u> <u>Balto. Md.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-01</u>	
		D. STREET ADDRESS (If rural, give location) <u>1525 N. Carey St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	B. DATE OF BIRTH <u>6/29/00</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charlotte Co. Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Logan</u>		14. MOTHER'S MAIDEN NAME <u>Alice Matthews</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-8836</u>		17. INFORMANT <u>Records</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) <u>metastatic Ca.</u>			
		(B) DUE TO			
		(C) DUE TO			
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10/6/66</u> 19 <u>66</u> to <u>10/7/66</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>10/7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Irvin M. Sopher</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Irvin M. Sopher</u>		23D. ADDRESS <u>University Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct. 12, 1966</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1966</u>	25B. NAME OF REGISTRAR <u>Robert E. Feltner</u>	25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		ADDRESS <u>3199 Schwardus</u>	

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BALTIMORE CITY HEALTH DEPARTMENT

66 10165

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ISSAC

FROST

2. DATE AND HOUR PRONOUNCED DEAD

October 4, 1966

11:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

705 Edgewood Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

June 2, 1937

9. AGE (in years  
lost day)

27

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Frost

14. MOTHER'S MAIDEN NAME

Maggie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Henry Frost 1135 Stricker Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of back with perforation  
of heart.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

200 block of Robert St.

21D TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 4 '66 10:35

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Shot in back

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-10-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

George Kelson 1348 N. Calhoun St.



VALLEY FOUNTAIN

CONFIDENTIAL

2



1  
B-000

66 10166

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 66 10166

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FREDDIE

BEA

2. DATE AND HOUR PRONOUNCED DEAD

October 7, 1966

2:04 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Balto. City Hospital  
314. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4104 Cranston Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 10, 1935

9. AGE (In years  
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Nellis Bea

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

224-44-4275

17. INFORMANT

ADDRESS

Doll Bea 4104 Cranston Ave.

18. E9123

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive Lacerations of Trunk with  
DUE TO Partial Evisceration

(B) DUE TO

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

3700 Block East Monument Street

21D. TIME  
OF INJURY  
(APPROX.)

10

7

'66

1:30

m.

21E. INJURY OCCURRED

WHILE AT  
WORK☒NOT WHILE  
AT WORK☐

21F. HOW DID INJURY OCCUR?

Main cable broke and  
bucket of "back hoe" fell on subject

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-11-66

23C. NAME of CEMETERY or CREMATORY

Church Cemetery

23D. LOCATION

(City, town, or county)

(State)

Northumberland, Va.

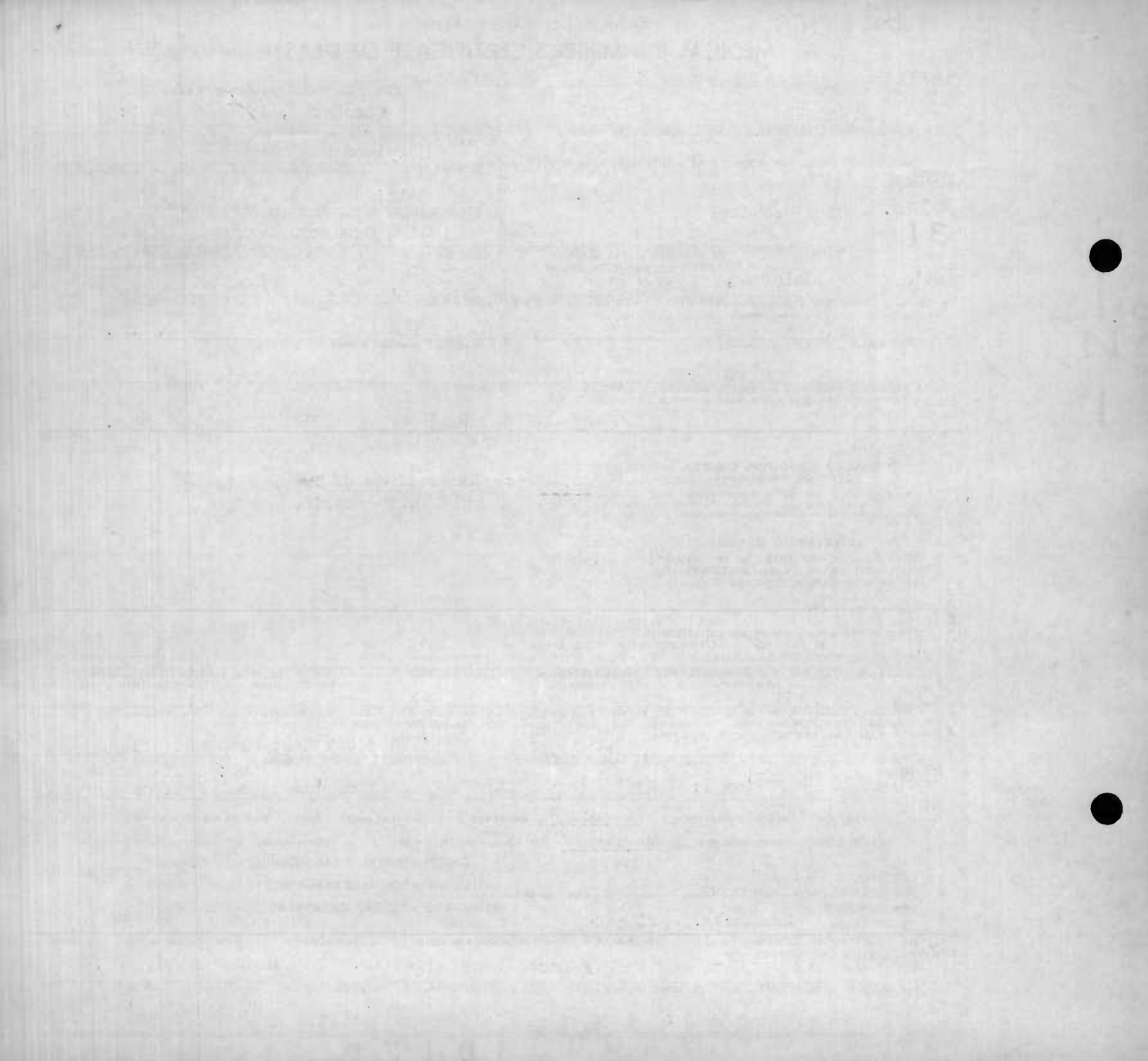
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

George Kelson 1348 Calhoun Street



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10167				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10167	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Alfreda ERAMER Robertson</b>				2. DATE AND HOUR OF DEATH <b>10-6-66</b>		<b>7<sup>07</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Baltimore, Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1908 Pennsylvania Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7-14-20</b>	9. AGE (In years lost birthday) <b>45</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Kramer</b>				14. MOTHER'S MAIDEN NAME <b>Alfreda Whitmore</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <b>William Robertson</b> ADDRESS <b>1908 PENNA. AVE</b>			
18. I <b>171X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia - pulmonary metastasis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Carcinoma of Cervix</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —				CAUSE OF DEATH (A) DUE TO <b>Pneumonia - pulmonary metastasis</b> (B) DUE TO <b>Carcinoma of Cervix</b> (C) —		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? —		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>10-6-66 8/65</u> 19 to <u>10-6-66</u> 19, that (I) <u>we</u> lost saw the deceased alive on <u>10-6-66</u> 19 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death.							
23A. SIGNATURE <b>J. C. Hisey</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-6-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>John C. Hisey</b>				23D. ADDRESS M.D. <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-11-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>George Kelson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1348 CANNOUN ST.</b>			

Received of J. C. [unclear]

for [unclear]

[unclear]

Received of [unclear]

for [unclear]

[unclear]

[unclear]

[unclear]

[unclear]

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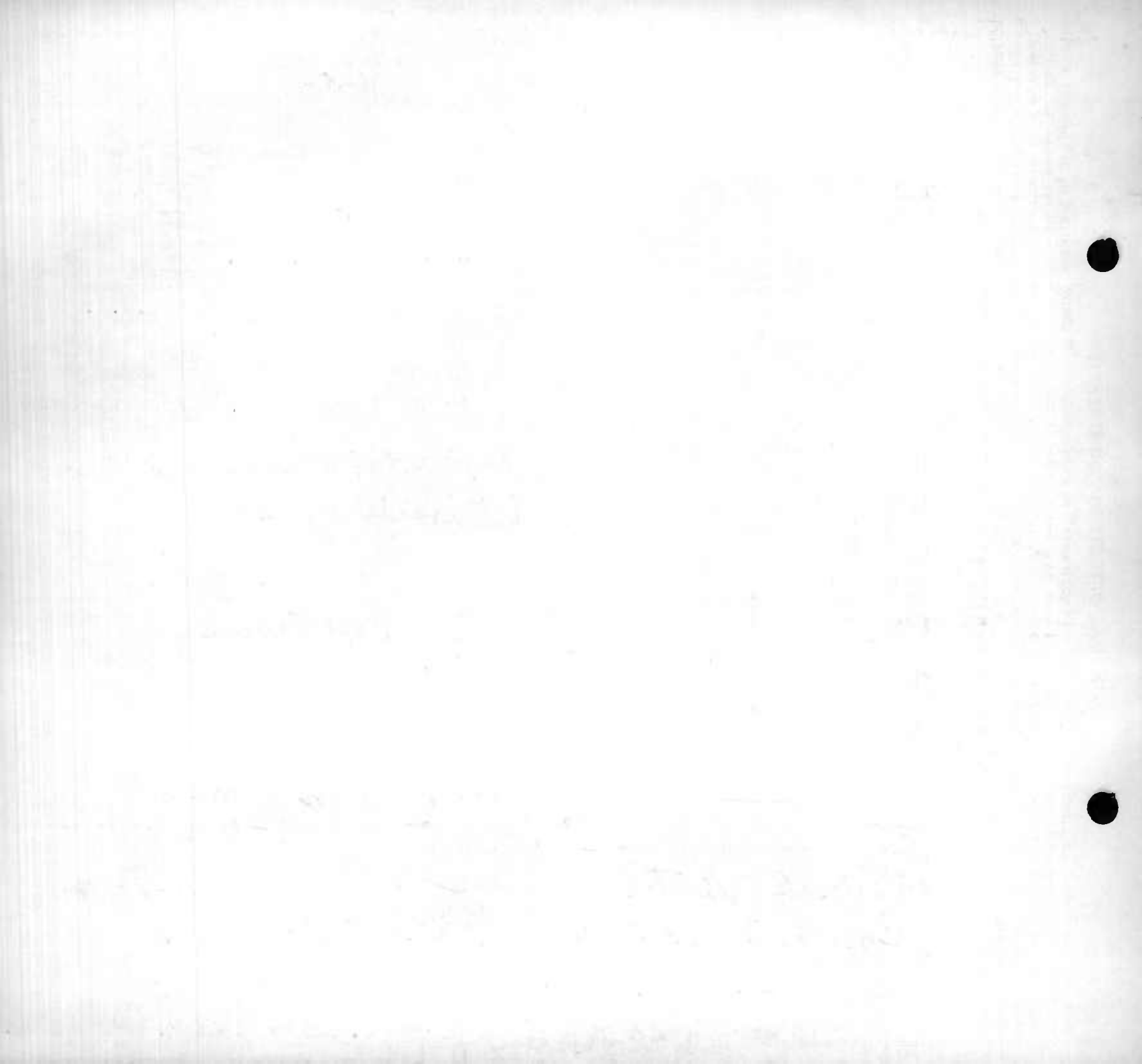
[unclear]

[unclear]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10168</u>	
BIRTH NO. <u>66 10168</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Samuel Lipscomb</u>		2. DATE AND HOUR OF DEATH <u>10-5-66</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3966 Penhurst Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8-20-95</u>	9. AGE (In years last birthday) <u>71 yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Bobby Lipscomb</u>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-6477</u>		17. INFORMANT <u>Eulah Lipscomb</u>	
18. <u>4201</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Essential Hypertension</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>10-1</u> 19 <u>66</u> to <u>10-4</u> 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>10-1</u> 19 <u>66</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Charles R. Venter</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>10-8-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles R. VENTER</u>		23D. ADDRESS <u>2320 Eutaw Place</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-8-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>George G. Kelson</u>	
				ADDRESS <u>1348 N. Calhoun St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10169		CERTIFICATE OF DEATH		Registered No. 66 10169	
1. NAME OF DECEASED (Type or Print) <b>Peter Sprainis</b>						2. DATE AND HOUR OF DEATH <b>October 9, 1966</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 3418 Fait Avenue</b>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3418 Fait Ave</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept. 18, 1889</b>		9. AGE (In years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer &amp; Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-01-6740</b>		17. INFORMANT <b>Arthur Cate 3418 Fait Ave.</b>			
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Anteriorly to C.V. Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>0</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Hypertension</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>February 24, 1966</b> to <b>October 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>October 6, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Jason H. Gaskel</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <b>10-10-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Jason H. Gaskel</b>						23D. ADDRESS <b>637 S. Conkling St. Balt. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 12, 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Wm Cook-Brooks Inc.</b>		ADDRESS <b>St. Paul &amp; Preston</b>			



Company Treasurer  
attn: Mr. C. V. Jones

Apprentice

Order of the  
February 11, 1900

10-11-12


EST. S. Conkling & Co.

James H. Gaskel  
James H. Gaskel



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

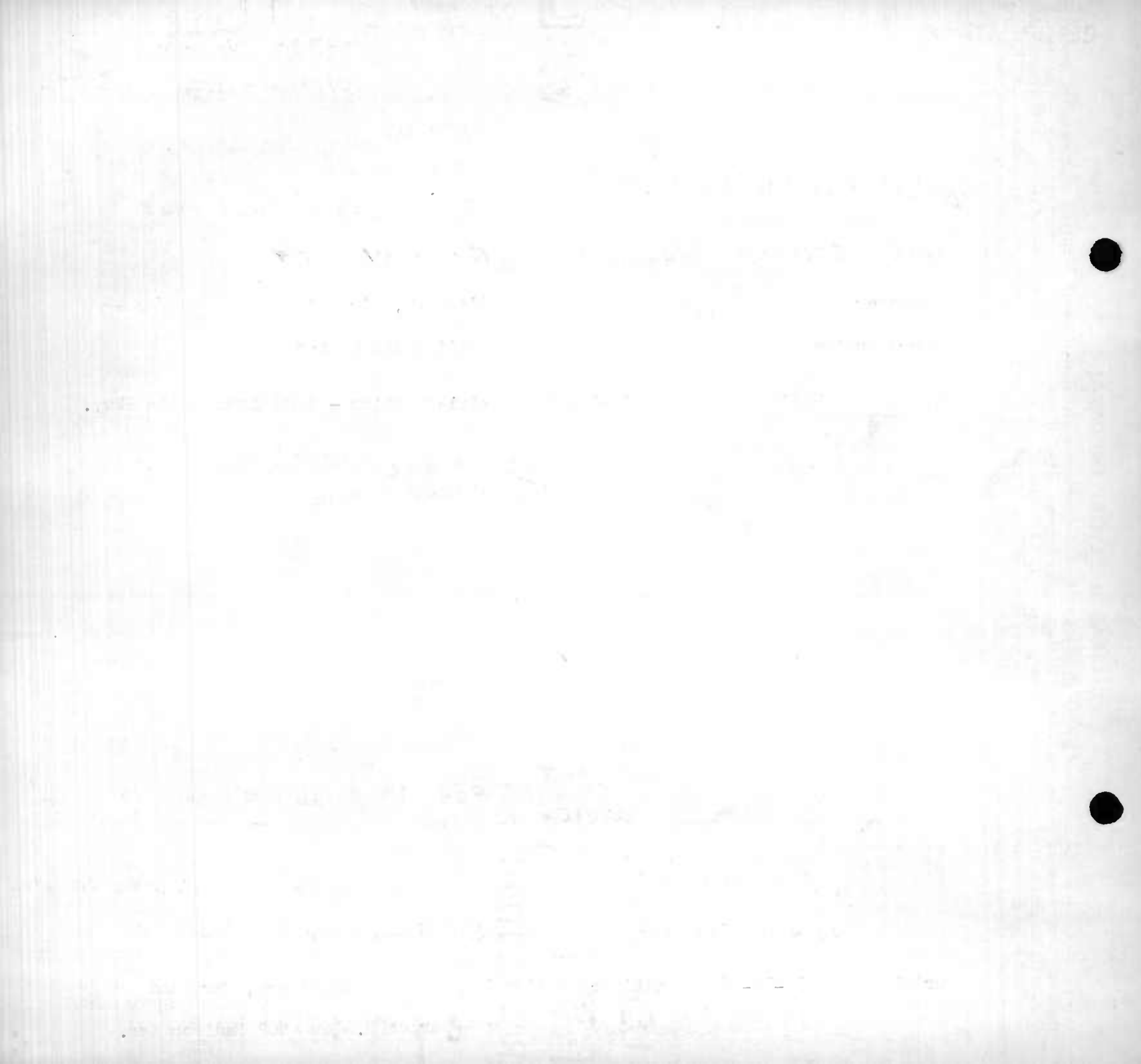
BIRTH NO. 66 10170		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 10170	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>DALLAS F. NICHOLAS</b>			2. DATE AND HOUR OF DEATH <b>OCTOBER 7, 1966</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>3517 N. HILTON ROAD</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>  D. STREET ADDRESS (If rural, give location) <b>3517 N. HILTON ROAD</b>		
5. SEX <b>MALE</b>	6. RACE <b>COLORED</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV. 24, 1903</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months Days Hours Min. 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAWYER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>	11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>LUTHER NICHOLAS</b>			14. MOTHER'S MAIDEN NAME <b>CARINA CAMPBELL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-38-8543</b>	17. INFORMANT ADDRESS <b>IDA N. NICHOLAS - 3517 N. HILTON ROAD</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma, tracheo-bronchial</b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 1966</b> to <b>Oct. 7, 1966</b> that (I) (we) last saw the deceased alive on <b>Oct. 6, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/10/66</b>
23C. PHYSICIAN'S NAME (Type) <b>GEORGE McDONALD</b>			23D. ADDRESS M.D. <b>844 N. CAREY ST., BALTIMORE, MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-11-66</b>	24C. NAME of CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT. 10 1966</b>		25B. NAME OF REGISTRAR <b>Charles R. Law</b>		25C. FUNERAL DIRECTOR ADDRESS <b>CHARLES R. LAW 802 MADISON AVE.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10171	
BIRTH NO. 66 10171		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SUTTON Harold B.		2. DATE AND HOUR OF DEATH 10/10/66 - 3:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSP. of MARYLAND		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-38 D. STREET ADDRESS (If rural, give location) 3228 GWYNN FALLS PKWY			
5. SEX MALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	B. DATE OF BIRTH 10-11-1911	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ditchley, Virginia	
13. FATHER'S NAME Harry Sutton		14. MOTHER'S MAIDEN NAME Eliza Ann Carter		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 214-14-9457		17. INFORMANT ADDRESS Vivian Sutton - 3228 Gwynn Falls Pkwy.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) TERMINAL CARCINOMA OF RIGHT TONSIL (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 Months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 8th 1966 to OCTOBER - 10 1966, that (I) (we) last saw the deceased alive on OCTOBER - 10 - 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose R. Sturich		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 10/1966	
23C. PHYSICIAN'S NAME (Type) JOSE R. STURICH		23D. ADDRESS M.D. 2519 Gatehouse Dr. BALTO - 7.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-13-66		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1966		25B. NAME OF REGISTRAR Robert E. Sturich		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.	



J-200

66 10172

BALTIMORE CITY HEALTH DEPARTMENT

66 10172

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>BESSIE M. JOYCE</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 4, 1966 5:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>30 Winters Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>2-17-1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>82</b>
13. FATHER'S NAME <b>Isaac Marshall</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Matilda Carter</b>	
17. INFORMANT <b>J. Harvey Joyce</b>		ADDRESS <b>- 3218 Sequoia Ave.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Malnutrition and Dehydration</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>10-7-66</b>	
23C. NAME of CEMETERY or CREMATORY <b>Western Star</b>		23D. LOCATION (City, town, or county) (State) <b>Catonsville, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
24C. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave.</b>	

WACLEY HONGE

CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10173		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) ANNIE B. WHIDBEE (BERTHA)		2. DATE AND HOUR OF DEATH 10/5/66 9:15PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. #21224 31		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3501 FAIRVIEW AVENUE #21216 15-38	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 9-26-93
9. AGE (In years (last birthday)) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MONGO TATE		14. MOTHER'S MAIDEN NAME SUSAN KENT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-10-3730 D	
17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. BALTO., MD.		ADDRESS #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 30 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/2 1965 to 10/5 1966, that (I) (we) last saw the deceased alive on 10/5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Judith Hall		23B. DATE SIGNED 10/5-66	
23C. PHYSICIAN'S NAME (Type) JUDITH HALL		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-10-66	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1966		25B. NAME OF REGISTRAR Robert E. Farkner	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10174</u>	
BIRTH NO. <u>66 10174</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Lydia Alice Corbin</u>		2. DATE AND HOUR OF DEATH <u>October 10, 1966</u> M.	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>520 Poplar Grove St. Baltimore, Maryland</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
D. STREET ADDRESS (If rural, give location) <u>520 Poplar Grove St.</u>		E. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-28-1901</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Tappahannock, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Phillip E. Beale</u>		14. MOTHER'S MAIDEN NAME <u>Clara B. Nelson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-0074</u>		17. INFORMANT <u>Sadie Williams, 520 Poplar Grove St</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive Cardiac Vascular Disease</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/13/59</u> to <u>10/10/66</u> that (I) (we) last saw the deceased alive on <u>10/4/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Garner</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/10/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. CARNEER</u>		23D. ADDRESS <u>1005 W Lafayette Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>St. Johns Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Tappahannock, Virginia</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Fickens</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law</u>	
25D. ADDRESS <u>802 Madison Ave.</u>					

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E-436

66 10175

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 10175

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RALPH W. ELDRIDGE

2. DATE AND HOUR PRONOUNCED DEAD

October 8, 1966 8:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1633 N. Montford Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1633 N. Montford Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3-19-1916

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Brick Setter

10B. KIND OF BUSINESS OR INDUSTRY

Brick Co.

11. BIRTHPLACE (State or foreign country)

Petersburg, VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ralph W. Eldridge

14. MOTHER'S MAIDEN NAME

Sarah Eldridge

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

224-05-9941

17. INFORMANT

Mary Purnell

ADDRESS

1633 Montford Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-12-66

23C. NAME of CEMETERY or CREMATORY

Arbutus

23D. LOCATION

(City, town, or county)

BA/Ho.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

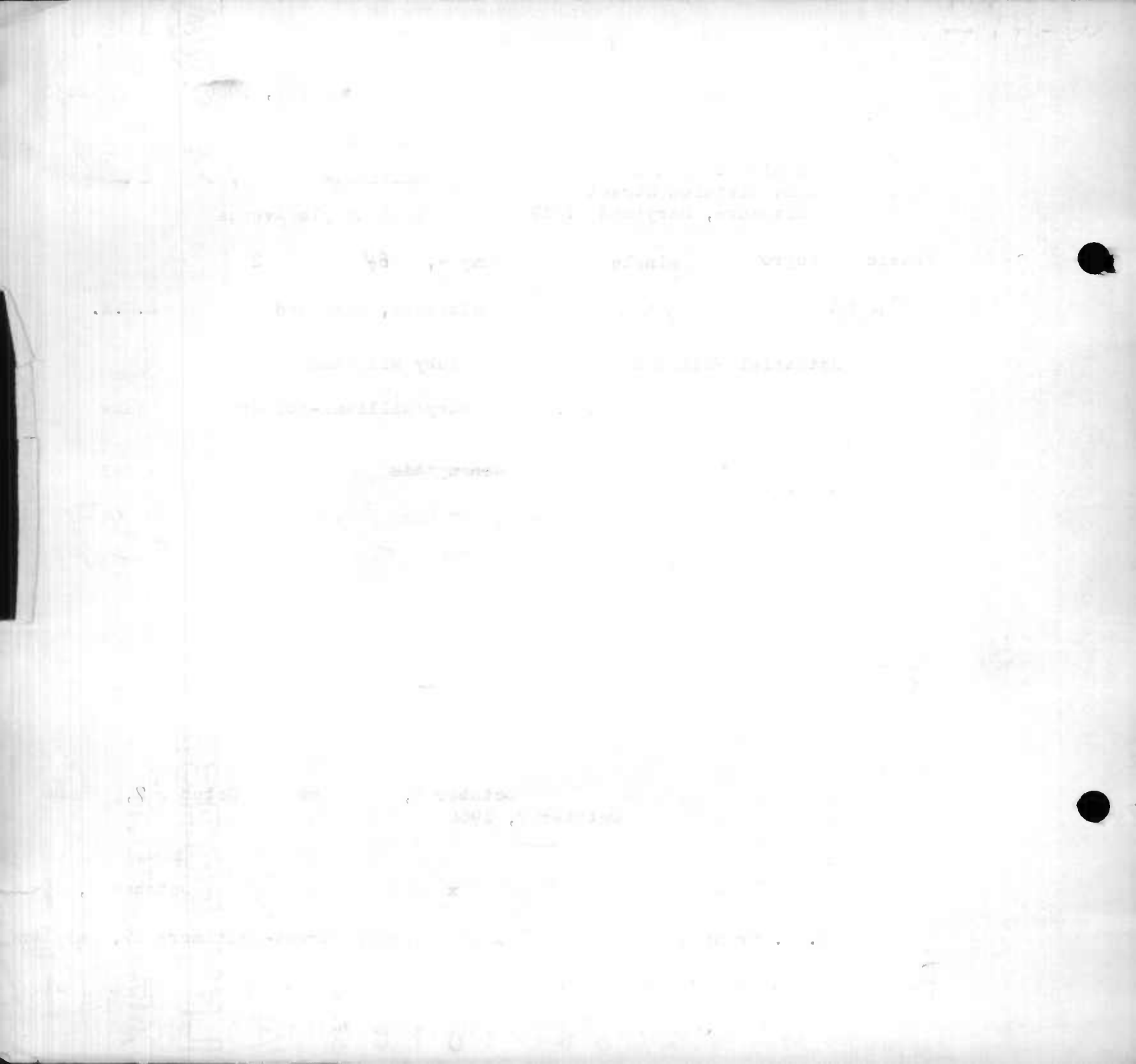
MORTON &amp; Pyle - 1701 LAWRENCE ST.

WALLER FORGE

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10176</b>	
BIRTH NO. <b>64-115786 10176</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Geraldine Williams</b>			2. DATE AND HOUR OF DEATH <b>October 7, 1966 12:30a.m.</b>		
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland 21217</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1058 Argyle Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>single</b>	8. DATE OF BIRTH <b>May 4, 1964</b>	9. AGE (In years lost birthday) <b>2</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Nathaniel Williams</b>			14. MOTHER'S MAIDEN NAME <b>Ruby Williams</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>N/A</b>	17. INFORMANT <b>Ruby Williams-mother</b>		ADDRESS <b>same</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INTERSTITIAL PNEUMONIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day in hospital</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			20. CAUSE OF DEATH (A) <b>INTERSTITIAL PNEUMONIA</b> (B) <b>ENTERITIS</b> (C) <b>CONGEST?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 6, 1966</b> to <b>October 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>October 7, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel H. Krasnow</b>				23B. DATE SIGNED <b>October 7, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. H. Krasnow</b>				23D. ADDRESS <b>1514 Division Street-Baltimore 17, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-11-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION <b>Baltimore</b>		24E. STATE <b>Maryland</b>		24F. ADDRESS <b>1701 Laurens St.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert J. Taylor</b>		25C. FUNERAL DIRECTOR <b>Working Dgt H.F.H.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

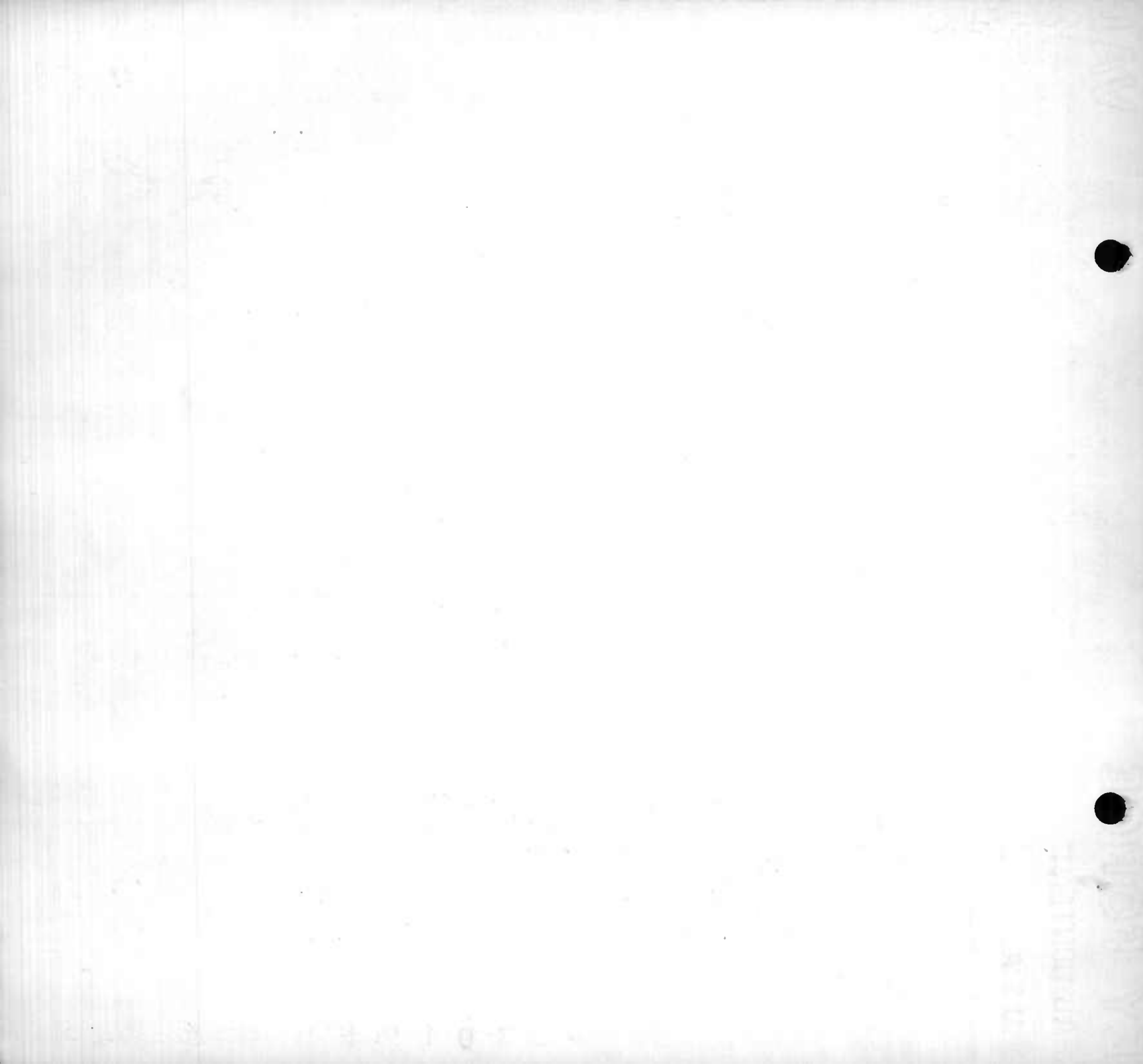
BIRTH NO. 66 10177		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10177	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CORENA GOESBERRY		2. DATE AND HOUR OF DEATH OCT 9 '66 12 <sup>10</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL BALTIMORE		A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-01			
		D. STREET ADDRESS (If rural, give location) 1907 W. FAIRMOUNT ST.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) UNKNOWN	8. DATE OF BIRTH 8-14-1911	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? US A		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT SISTER- MARY E. BASKET S/A	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Peritonitis DUE TO (B) Mesenteric Thrombosis DUE TO (C) Aortic CVD		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from 9/27/66 to 10/9 19 66, that (I) (we) last saw the deceased alive on OCT 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy Kenney Gray		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-9-66	
23C. PHYSICIAN'S NAME (Type) TIMOTHY KENNEY GRAY		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-11-66		24C. NAME of CEMETERY or CREMATORY Arbutus Mem Pk. Bk. Md.	
24D. LOCATION (City, town, or county) (State) BALTO. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 10 1966			
25B. NAME OF REGISTRAR A. J. F. F. F.		25C. FUNERAL DIRECTOR Norton & Dyett			
25D. ADDRESS 1701 LAURENS ST.					

WILLIAM BOOTH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 10178		CERTIFICATE OF DEATH		66 10178	
1. NAME OF DECEASED (Type or Print) <b>SMITH, Pearl L</b>			2. DATE AND HOUR OF DEATH <b>10/7/66 1815A.M.</b>		
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A. C.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SEVERN 52-00</b>		
D. STREET ADDRESS (If rural, give location) <b>ROUTE 2 BOX 219 C</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5-22-97</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Burns &amp; Cowburn</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>KEMP SHAW</b>			14. MOTHER'S MAIDEN NAME <b>CHARITY TAYLOR</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Alonca Smith Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b> <b>Diphtheria &amp; ASCVD</b> <b>an CHF</b>			INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>10/7 10/2</b> 19 <b>66</b> to <b>10/7</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>10/7</b> 19 <b>66</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>do not</del> ) view the body after death.					
23A. SIGNATURE <b>David F. Fedson</b> M.D.				23B. DATE SIGNED <b>10/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID F. FEDSON</b>			23D. ADDRESS <b>The Johns Hopkins Hospital, Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-10-66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Not known</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <b>D. F. Fedson</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Gray &amp; Wilson 1000 Brantley Dr</b>			



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10179	
C-6 36 66 10179				66 10179	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>ESTHER CARTER</u>		
2. DATE AND HOUR OF DEATH <u>10/7/66</u>			<u>6:40 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
D. STREET ADDRESS (If rural, give location) <u>1119 N. DALLAS ST. #21213</u>			E. STREET ADDRESS (If rural, give location) <u>8-07</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>10/6/03</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM Owens</u>		14. MOTHER'S MAIDEN NAME <u>MARY Robinson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>RECORDS: BCH 4940 EASTERN AVENUE #21224</u>	
18. <u>1977-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>RESPIRATORY INSUFFICIENCY - 24/hrs</u> DUE TO (B) <u>METASTATIC ADENOCARCINOMA - GALL</u> DUE TO (C) <u>PRIMARY UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>none</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> 19 <u>66</u> to <u>10/7</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>10/7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Judith Hall</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>10/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. JUDITH HALL</u>				23D. ADDRESS M.D. <u>4940 EASTERN AVENUE #21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-12-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Wickham Cmt</u>	
24D. LOCATION (City, town, or county) <u>Brooklyn Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Feltner</u>	
24G. FUNERAL DIRECTOR <u>Choy O. Wilson</u>		24H. ADDRESS <u>1119 N. Dallas St. #21213</u>		24I. SIGNATURE <u>Choy O. Wilson</u>	

WICHITA BOARD

## CERTIFICATE OF DEATH

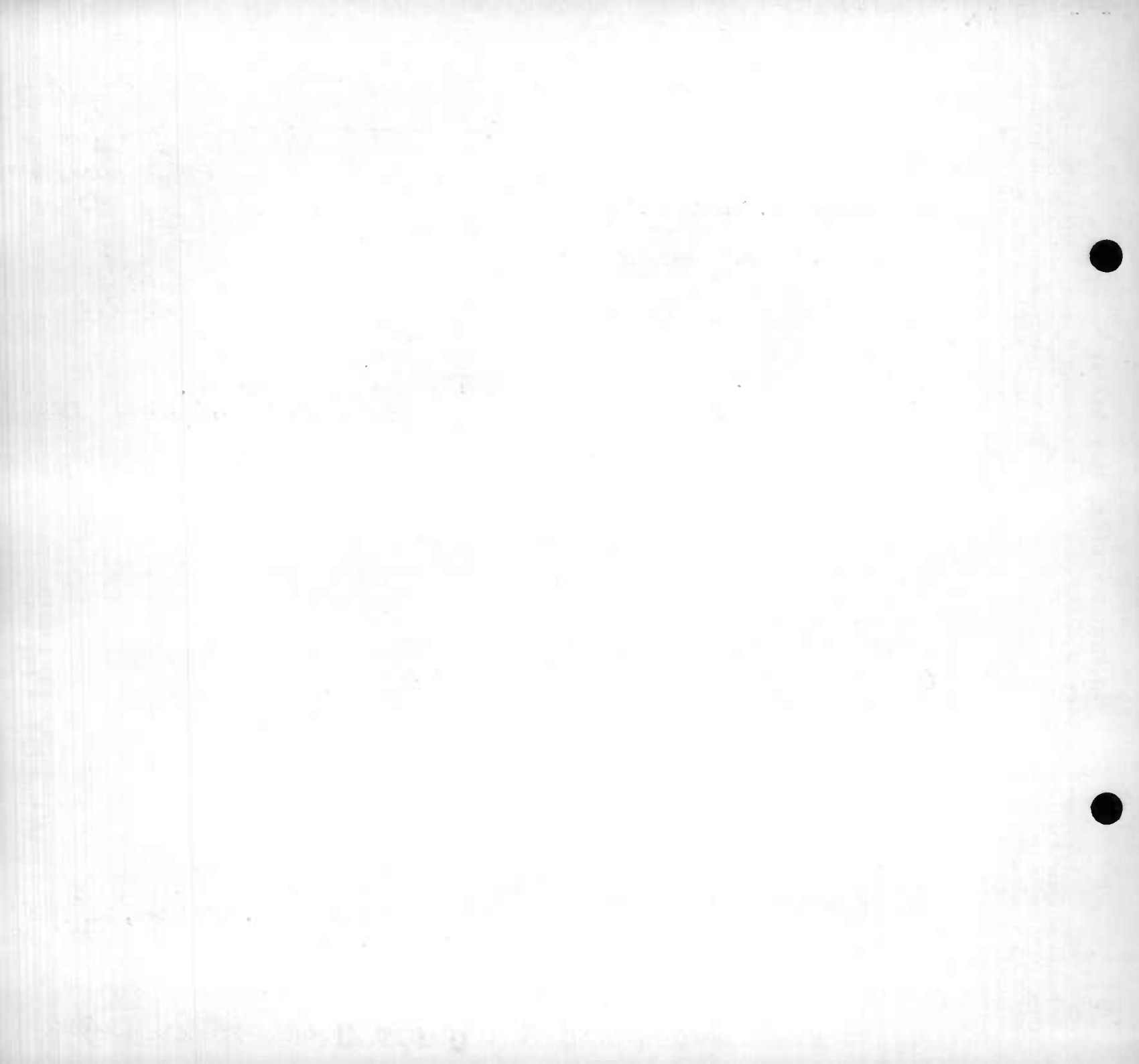
Registered No.

## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ware, Bertha</i>		2. DATE AND HOUR OF DEATH <i>12<sup>30</sup> am 10/5/66 A. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>RT 2</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hosp #21224</i> <i>4940 Eastern Ave. Baltimore, Maryland</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Severna Park Md 21146-003</i>			
D. STREET ADDRESS (If rural, give location) <i>Box 288 RT 2 52-00</i>							
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>8-26-98</i>	9. AGE (In years lost birthday) <i>68</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Willis</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH: Records 4940 Eastern Ave. Chert</i>		ADDRESS <i>Baltimore, Maryland # 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>15381</i>				CAUSE OF DEATH (A) <i>Carcinoma of the colon 1 yr</i> DUE TO (B) _____ DUE TO (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9/27/66</i> 19 <i>66</i> to <i>10/5</i> 19 <i>66</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>9/5</i> 19 <i>66</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> <i>(We)</i> <i>(did)</i> (did not) view the body after death.							
23A. SIGNATURE <i>Mary Ann Sullivan</i> M.D.						23B. DATE SIGNED <i>10/5/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Mary Ann Sullivan</i> M.D.						23D. ADDRESS <i>4940 Eastern Ave. Baltimore, Maryland # 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-8-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Int Capay Out</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Graydoner Brewster</i> ADDRESS			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 10181	
66 10181										66 10181	
BIRTH NO.										A	
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)					JAMES BROWN					2. DATE AND HOUR OF DEATH 10-4-66 2.25 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY						
33 JOHNS HOPKINS HOSPITAL					MARYLAND						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)						
					BALTIMORE 2.						
					D. STREET ADDRESS (If rural, give location)						
					649 STERLING ST.						
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 9-20-1904		9. AGE (In years last birthday) 61		If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Labor						St. Marys Md			U.S.A.		
13. FATHER'S NAME WESLEY BROWN						14. MOTHER'S MARDEN NAME MARY COOK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
no						Estella Brown			Lanue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
493X I Sepsis Pneumonia									24 hrs 4 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						Ascud					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2						Yes		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 10/3 1966 to 10/4 1966, that (I) (we) last saw the deceased alive on 10/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Harmon J. Eyne M.D.										23B. DATE SIGNED 10/4/66	
23C. PHYSICIAN'S NAME (Type) Harmon Eyne				23D. ADDRESS 601 North Broadway Bldg, Md							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial		10-8-66		Mt Auburn Cmt				Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR				ADDRESS			
OCT 10 1966		Robert E. Taylor		Gray C. Wilson				100 Brantley Rd			

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10/4

Harmon  
Harmon  
of Edge  
Edge

101 North Broadway St. 10/4

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10182		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10182	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Alford Parker</i>		2. DATE AND HOUR OF DEATH <i>Oct 3-1966</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>001131 N. Carey St</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore md 16-01</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1131 N. Carey St</i>			
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>MAY 16, 1875</i>	9. AGE (In years last birthday) <i>91</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <i>A. A. County Md</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>Ellen ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Estelle Parker</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Generalized Atherosclerosis -</i> (B) <i>Coronary artery, cerebral</i> (C) <i>Cardiac</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 20</i> 19 <i>66</i> to <i>Oct 3</i> , 19 <i>66</i> , that (I) <del>was</del> last saw the deceased alive on <i>20 Sept</i> 19 <i>66</i> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>viewed</del> (did not) view the body after death.					
23A. SIGNATURE <i>Smith H. Carter</i>				23B. DATE SIGNED <i>7 Oct 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Smith H. Carter</i>				23D. ADDRESS <i>1007 Pennsylvania St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>10-7-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Airy Cem</i>	
24D. LOCATION <i>Balto md</i>		24E. CITY, town, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>R. G. E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Elmer D. Wilson</i>	
				ADDRESS <i>1000 Brantley Dr</i>	



66 10183

BALTIMORE CITY HEALTH DEPARTMENT

66 10183

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CARRIE

OMBAD

2. DATE AND HOUR PRONOUNCED DEAD

October 6, 1966

6:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

868 Park Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

11/1/02

9. AGE (In years  
last birthday)

64

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Weaver Cessna

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Catalino Ombao 868 Park Ave. Balto. Md.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Pneumonia and myocardial infarct  
complicating cerebral infarct

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Charles S. Springate  
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 6, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

10/10/66

23C. NAME of CEMETERY or CREMATORY

Green Mount Crematory

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR 1217 St. Paul St.

Wm. Cook-Brooks F.H.K Balto. Md. 21202

OCT 10 1966

Robert E. Fairbank

WALSH & CO.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10184		REGISTERED NO. 66 10184	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) HUBERT F. ROWAN				2. DATE AND HOUR OF DEATH October 7, 1966   1 25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 6412 SHERWOOD AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-11-08	9. AGE (In years last birthday) 58	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY Title Bldg.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS ROWAN			14. MOTHER'S MAIDEN NAME JULIA <del>HULIHAN</del> Hulihan				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 165-18-1185		17. INFORMANT Mrs. Valerie Rowan		ADDRESS Same	
18. <del>466X</del> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) <u>Prob. pulmonary embolus</u> DUE TO		30 min.	
				(B) <u>Venous thrombosis</u> DUE TO		~ 1 wk.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Acute Myocardial Infarction, Pulmonary Edema, Pneumonia</u>							
19A. DATE OF OPERATION 9/30/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>General artery insufficiency</u>		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>HT</u> (this hospital) attended the deceased from <u>9/23</u> 19 <u>66</u> to <u>10/7</u> 19 <u>66</u> , that <u>HT</u> (we) last saw the deceased alive on <u>10/7</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>HT</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James J. Corkins</u> JAMES T. CORKINS				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/7/66	
23C. PHYSICIAN'S NAME (Type) JAMES T. CORKINS				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/11/66		24C. NAME of CEMETERY or CREMATORY The Live Oak Cem.		24D. LOCATION (City, town, or county) (State) Walterboro South Carolina	
25A. DATE REC'D BY HEALTH DEPT. Oct 11 1966		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10185		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10185	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Violet Casey</b>		2. DATE AND HOUR OF DEATH <b>10-7-66 9:10 AM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>1-02</b> D. STREET ADDRESS (If rural, give location) <b>638 S. Potomac St</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>10-7-82</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>England</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-057639</b>		17. INFORMANT <b>D. Mrs. Carroll Fitzgerald</b> ADDRESS <b>same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		CAUSE OF DEATH (A) DUE TO <b>Myocardial Infarction</b> (B) DUE TO <b>Congestive Heart Failure</b> (C) DUE TO <b>ASCDI</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b> <b>several weeks</b> <b>several years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0 None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>10-7-66</b> to <b>10-7-66</b> , that (I) (we) last saw the deceased alive on <b>10-7-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Werner Beck</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-7-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Werner Beck</b>		23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc. Balto., Md.</b>	

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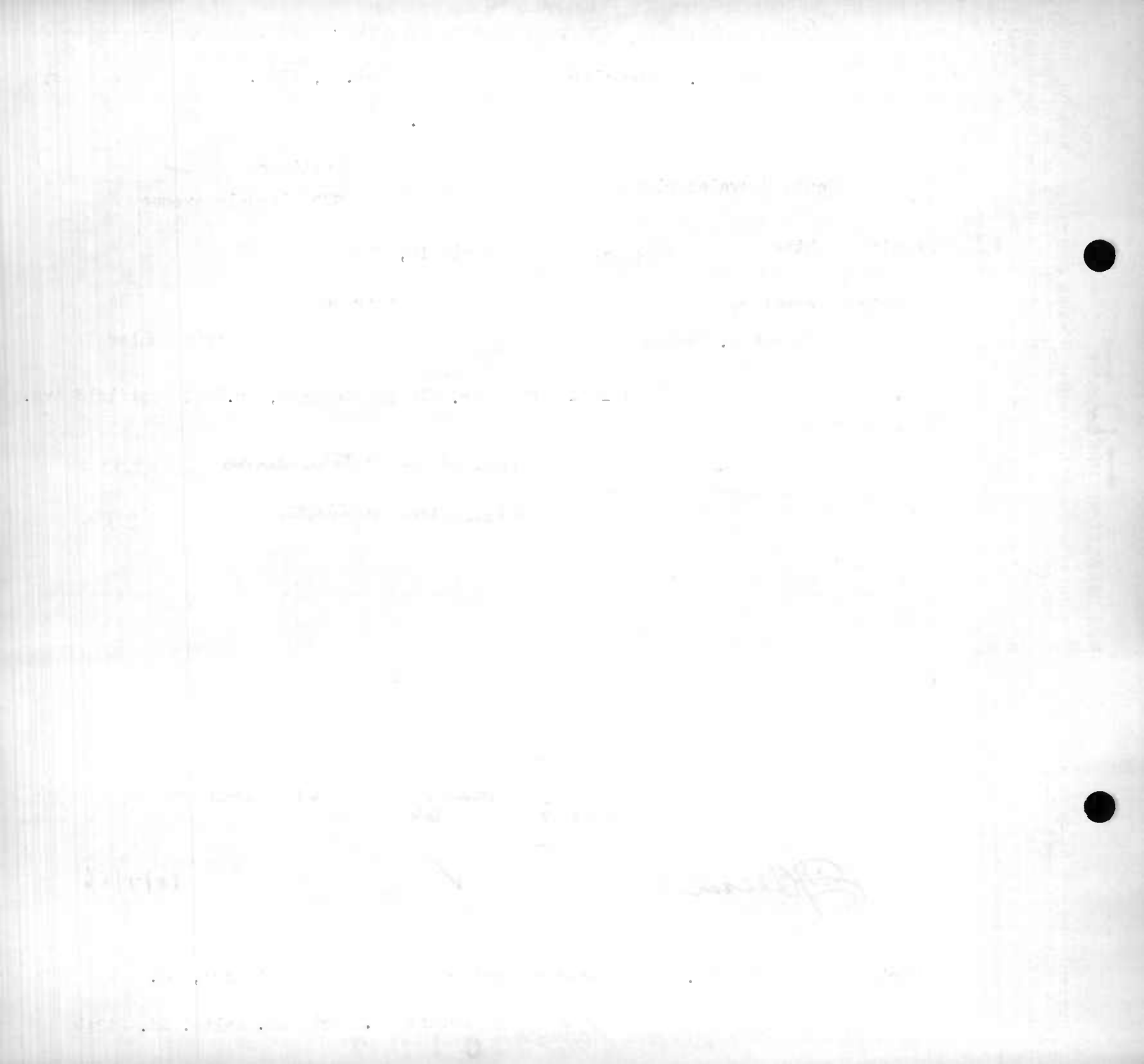
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10186</u>	
BIRTH NO. <u>66 10186</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Anna C. Henggeler</u>		2. DATE AND HOUR OF DEATH <u>Oct. 7, 1966.</u> <u>3.20 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>90 Gould Convalesarium</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>  D. STREET ADDRESS (If rural, give location) <u>2923 Glendale Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>April 14, 1878</u>	9. AGE (In years last birthday) <u>88</u>	10. Under 1 Yr. Months Days   11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph M. Henggeler</u>		14. MOTHER'S MAIDEN NAME <u>Anna Maria Kohler</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-3389</u>		17. INFORMANT <u>Mr. Alphons Reymann, Jr.</u> ADDRESS <u>2911 Westfield Ave.</u>	
18. <u>430.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Generalized arteriosclerosis</u> DUE TO (B) <u>Rheumatoid arthritis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1961</u> to <u>Oct 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 7, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		23D. ADDRESS <u>[Signature]</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/10/66.</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1966</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10187		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10187	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOUIS W. HELDMANN		October 8, 1966 10:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
residence:		2003 E. Belvedere Avenue		Maryland	
C. CITY OR TOWN (If outside city limits, give rural and give township)		Baltimore			
D. STREET ADDRESS (If rural, give location)		2003 E. Belvedere Ave.			
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	
8. DATE OF BIRTH 1-26-83		9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Heldmann	
14. MOTHER'S MAIDEN NAME Elizabeth Klunk		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-6368	
17. INFORMANT Mrs. Joseph Yenni		ADDRESS 2003 E. Belvedere Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Acute Embolic Stroke</i> DUE TO (B) <i>Chronic Arteriosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>August 13</i> 19 <i>66</i> to <i>October 8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>October 1</i> 19 <i>66</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i> Dr. Albert B. Bradley				23B. DATE SIGNED 10/10/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 4900 Belair Road, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 10/12/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - 5305 Harford Rd, 14		ADDRESS			



Chief Clerk  
Chief Clerk

Mr. D. B. Smith

Oct 18 1892

10/10/92

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

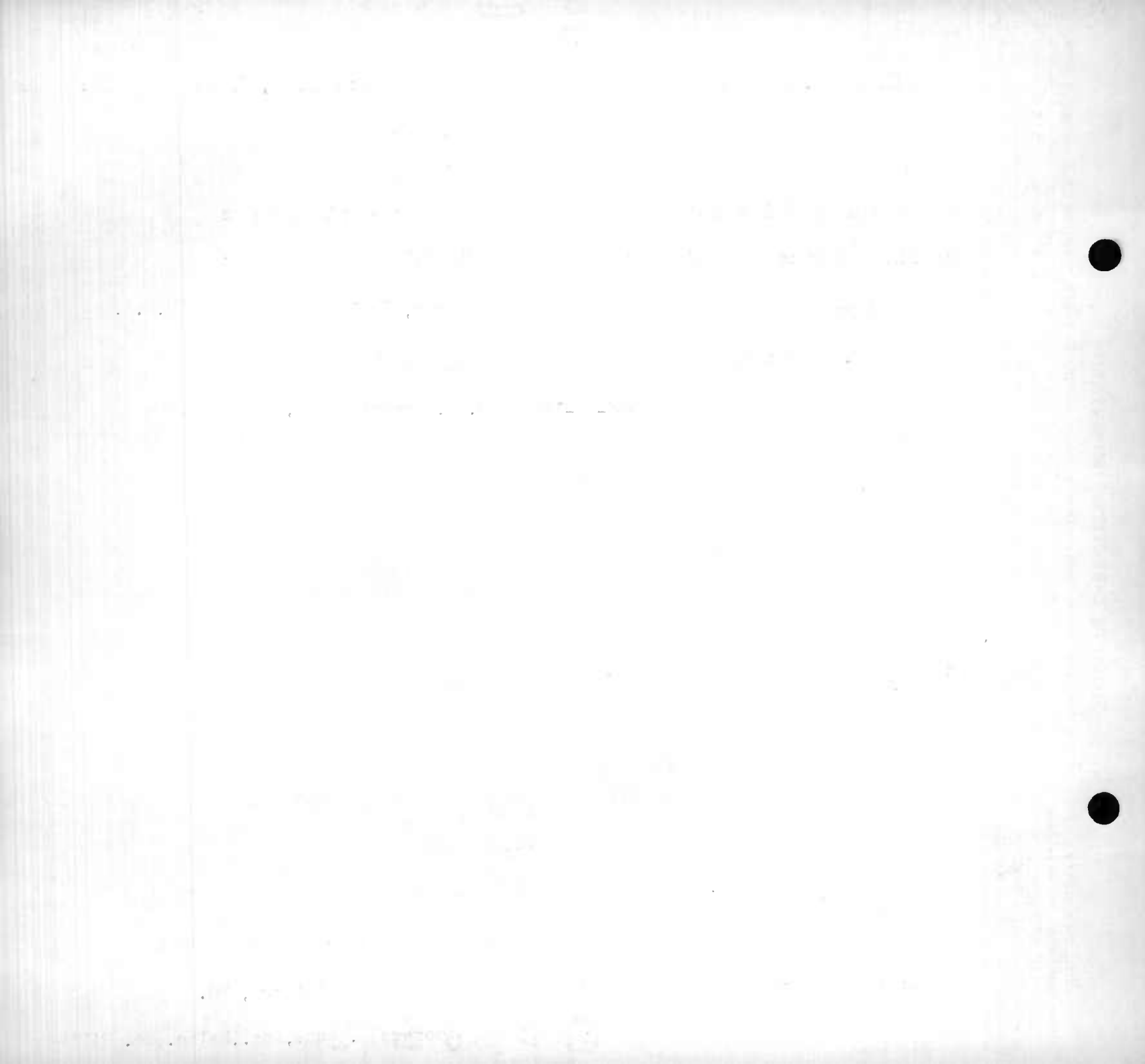
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10188	
BIRTH NO. 66 10188		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>VIRGINIA F. MYERS</b>			2. DATE AND HOUR OF DEATH <b>10/8/66 10:50 P.M.</b>		
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
D. STREET ADDRESS (If rural, give location) <b>3831 YOLANDO ROAD 21218</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>2-1-22</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Herbert B. Freeman</b>		
14. MOTHER'S MAIDEN NAME <b>Nellie G. Berterman</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>216-16-8320</b>			17. INFORMANT <b>Mr. Charles E. Myers, Jr.</b>		
18. CAUSE OF DEATH <b>72.20 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>GI Bleeding &amp; PUL pneumonia</b>			19. DATE OF OPERATION <b>0</b>		
20. AUTOPSY? (Yes or No) <b>No</b>			21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>9/23</b> 19 <b>66</b> to <b>10/8</b> 19 <b>66</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>10/8</b> 19 <b>66</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Peter F. Rosen</b>			23B. DATE SIGNED <b>10/8/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>PETER F. ROSEN</b>			23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Olivet Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisk</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md. 21214</b>			



# FUNERAL DIRECTOR: IMPORTANT

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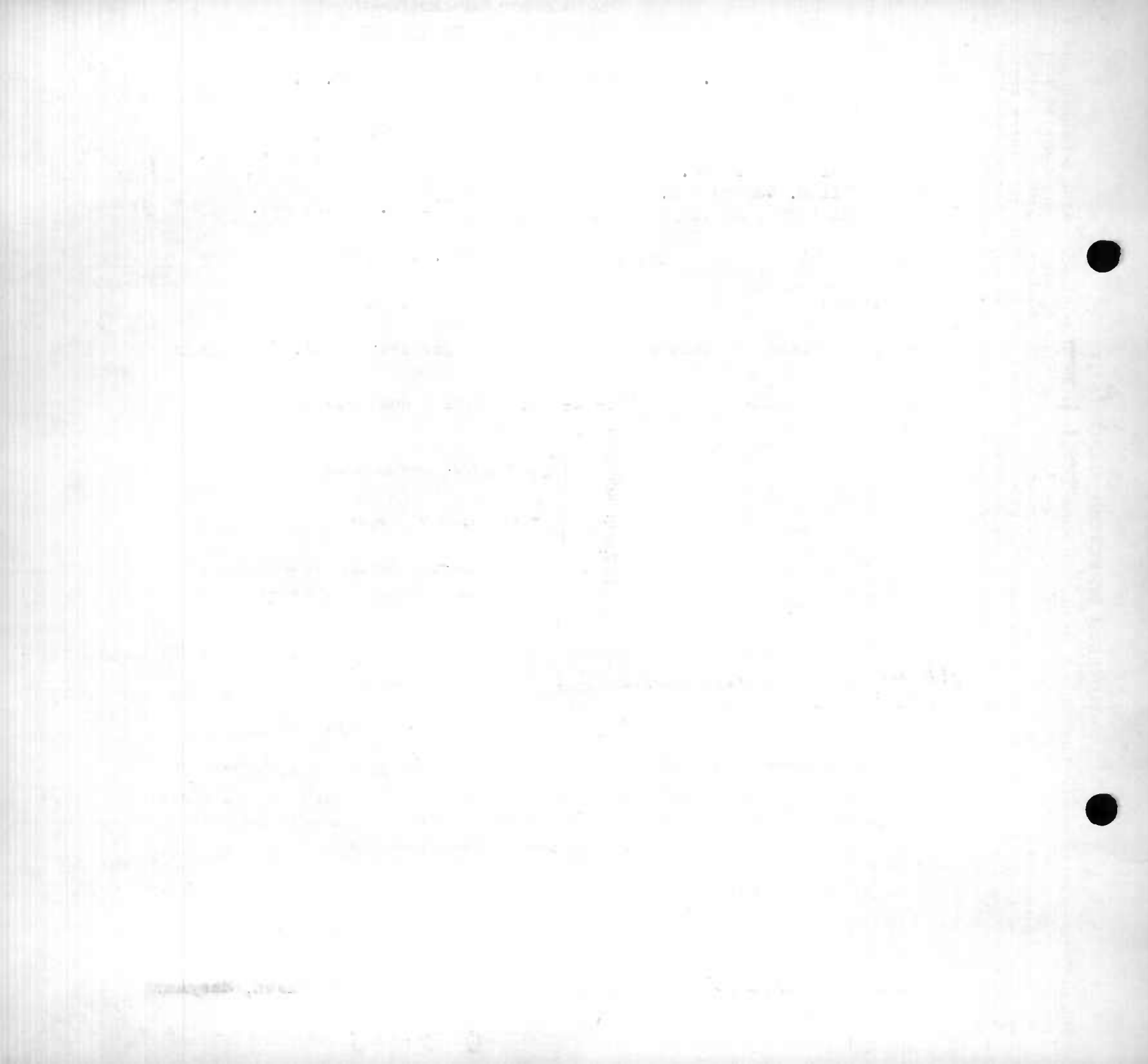
BIRTH NO. 66 10189		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10189	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Eileen R. Brown		2. DATE AND HOUR OF DEATH October 8, 1966 10:00 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3611 Echodale Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/27/12	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bangor, Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry H. Russell		14. MOTHER'S MAIDEN NAME Mary Black	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 065-03-1501		17. INFORMANT Mr. W. Ernest Brown, Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO L Febrile parietal Brain tumor (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Aug. 1966	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10/6-1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9:30 - 1966 to 10-8 - 1966, that (I) (we) last saw the deceased alive on 10-8 - 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sumio Uematsu		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-8-66	
23C. PHYSICIAN'S NAME (Type) Sumio Uematsu		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/11/66	24C. NAME of CEMETERY or CREMATORY Dulaney Valley Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10190		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10190	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Fannie G. Myers			2. DATE AND HOUR OF DEATH Oct. 8, 1966 8:45 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Wesley Home, Inc. 2211 W. Rogers Ave. Baltimore, Maryland 21209			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-15 D. STREET ADDRESS (If rural, give location) 2211 W. Rogers Ave. 9		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 10, 1886	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Thomas Walker			14. MOTHER'S MAIDEN NAME Margaret J. Falkner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 220-01-5117		17. INFORMANT ADDRESS Wesley Home Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			19. CAUSE OF DEATH Myocardial infarction Coronary occlusion Atherosclerotic cardiovascular disease		
19A. DATE OF OPERATION July 6, 1966			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture right hip		20A. AUTOPSY? (Yes or No) No No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 28, 1966 10 AM			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 224 W. Rogers Ave
21F. HOW DID INJURY OCCUR? Fall in room at home			22. I certify that (I) (this hospital) attended the deceased from 26 June 1966 to 8 October 1966, that (I) (we) last saw the deceased alive on 7 October 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
23A. SIGNATURE John W Barnaby			M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10 Oct 66
23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY			23D. ADDRESS 1531 E North Ave		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/12/66	24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons	
ADDRESS Baltimore, Md. North Ave.					

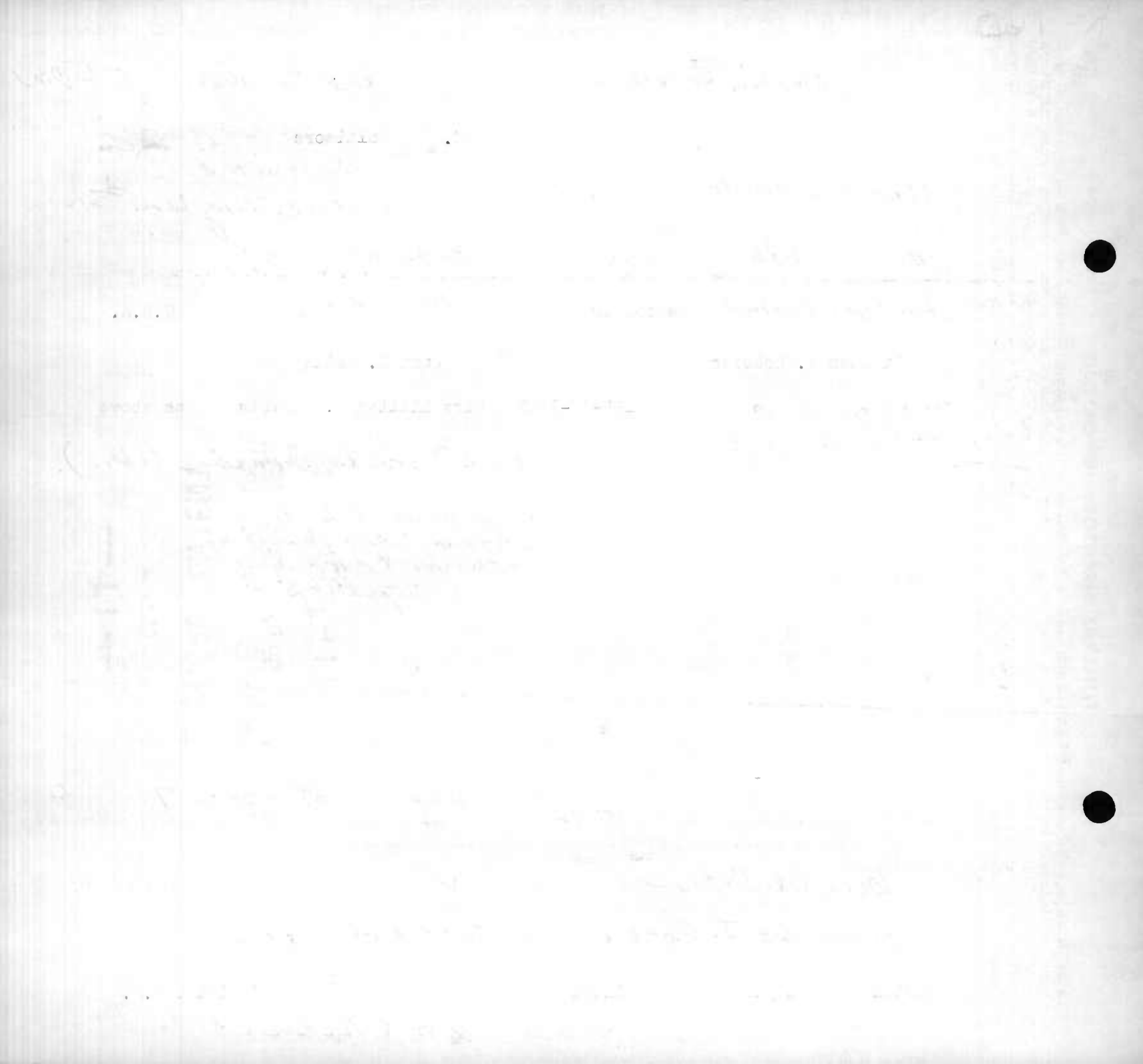




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10191</u>	
BIRTH NO. <u>66 10191</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>James Stephen Roberts</u>		2. DATE AND HOUR OF DEATH <u>Oct 7 - 1966. 5:45 PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Mem Hospital - (Emergency Room)</u>		A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto. Md. 21111</u>	
D. STREET ADDRESS (If rural, give location) <u>14 W. Cold Spring Lane #2110</u>		5. SEX <u>M</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>3-3-09</u> 9. AGE (In years last birthday) <u>57</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Line type operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Stephen F. Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Jane S. Bailey</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>152-05-3240</u>		17. INFORMANT <u>Miss Lillian G. Roberts</u> ADDRESS <u>as above</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO <u>Acute Myocardial Infarction (1 hr.)</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>1 - Hypertensive C.V.D.</u> <u>2 - Atherosclerotic Coronary Arteriosclerosis</u> (C) <u>3 - Previous Coronary</u> <u>Aug. 1964</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 1957</u> to <u>Oct. 7 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 7 - 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Bernard Cohen</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>10/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. BERNARD J. COHEN</u>				23D. ADDRESS <u>The Marylander App</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/10/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Hillside</u>	
24D. LOCATION (City, town, or county) (State) <u>Plainfield, N.J.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1966</u>		24F. NAME OF REGISTRAR <u>R. E. Fickner</u>	
24G. FUNERAL DIRECTOR <u>R. E. Fickner &amp; Sons</u>		24H. ADDRESS <u>Balto. Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
66 10192						66 10192	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				Brown, Louise Adelaide			
2. DATE AND HOUR OF DEATH				10-7-66 6 <sup>03</sup> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Univ. of Md. Hosp. BACT Md.				Md. BACT Balt. Co.			
38				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Parkville 53-00			
D. STREET ADDRESS (If rural, give location)				8719 Oakleigh Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. CITIZEN OF WHAT COUNTRY?
F	W	WID.	11-17-93	72			USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Nurse Aide				Md.		USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
JACOB Thoenes Bromwell			Lydia Beauchamp			No	
16. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS	
None			Son - Charles Brown			2027 Woodbourne Ave	
18. 175.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) METAST. CA, AMERICAN			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				ASH.D.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19/15/66		Metast. Ca.		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
No							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9.9.66 1966 10-7-66 that (I) (we) last saw the deceased alive on 10.7.66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
A. Waynes				10-7-66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Abdelgafar Awad				422 Arson Ave BALT 25			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/11/1966		Lorraine Park Cemetery		Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 11 1966		Robert E. Farkner		Wm. J. Farkner & Sons		Balt., Md. north Pa.	

Brown, George

1st BAPT

Unit of Mr. Hest

Bapt Mng

8114 Oakleaf Dr

11-15-85

F W M.D.

USA

MD

Housewife

1414 Barclay St

9200A Thomas

no

Gen - Charles

Robert A. Carter  
Genius Trust  
Flower, Anthony

ADHD

11/17/85

ok

10-1-85

for A. Jones  
Appo pher  
10-5-85

10-5-85  
X  
155

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10193</u>	
BIRTH NO. <u>66 10193</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JUNG, MARY, Lloyd</u>		2. DATE AND HOUR OF DEATH <u>10-8-66</u>   <u>5:05</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> <u>40 WILKENS &amp; CATON AVE.</u>		A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21223</u> D. STREET ADDRESS (If rural, give location) <u>508 PARKSLEY AVE.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6-12-80</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Evans</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL RECORDS</u> <u>CATON &amp; WILKENS AVE. 21229</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>434.21</u> <u>CONGESTIVE HEART FAILURE</u> <u>Left ventricular failure</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-6</u> <u>19 66</u> to <u>10-8</u> <u>19 66</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> <u>19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel C Jimenez</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>DR. JUAN GABRERA</u>				23D. ADDRESS <u>BALTO 29 MD</u> <u>ST. AGNES HOSPITAL, WILKENS &amp; CATON</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/11/1966</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>	
25C. FUNERAL DIRECTOR <u>Wm J. Fisher &amp; Sons</u>		25D. ADDRESS <u>Balto. Md.</u> <u>North &amp; Pacific</u>		25E. ADDRESS	

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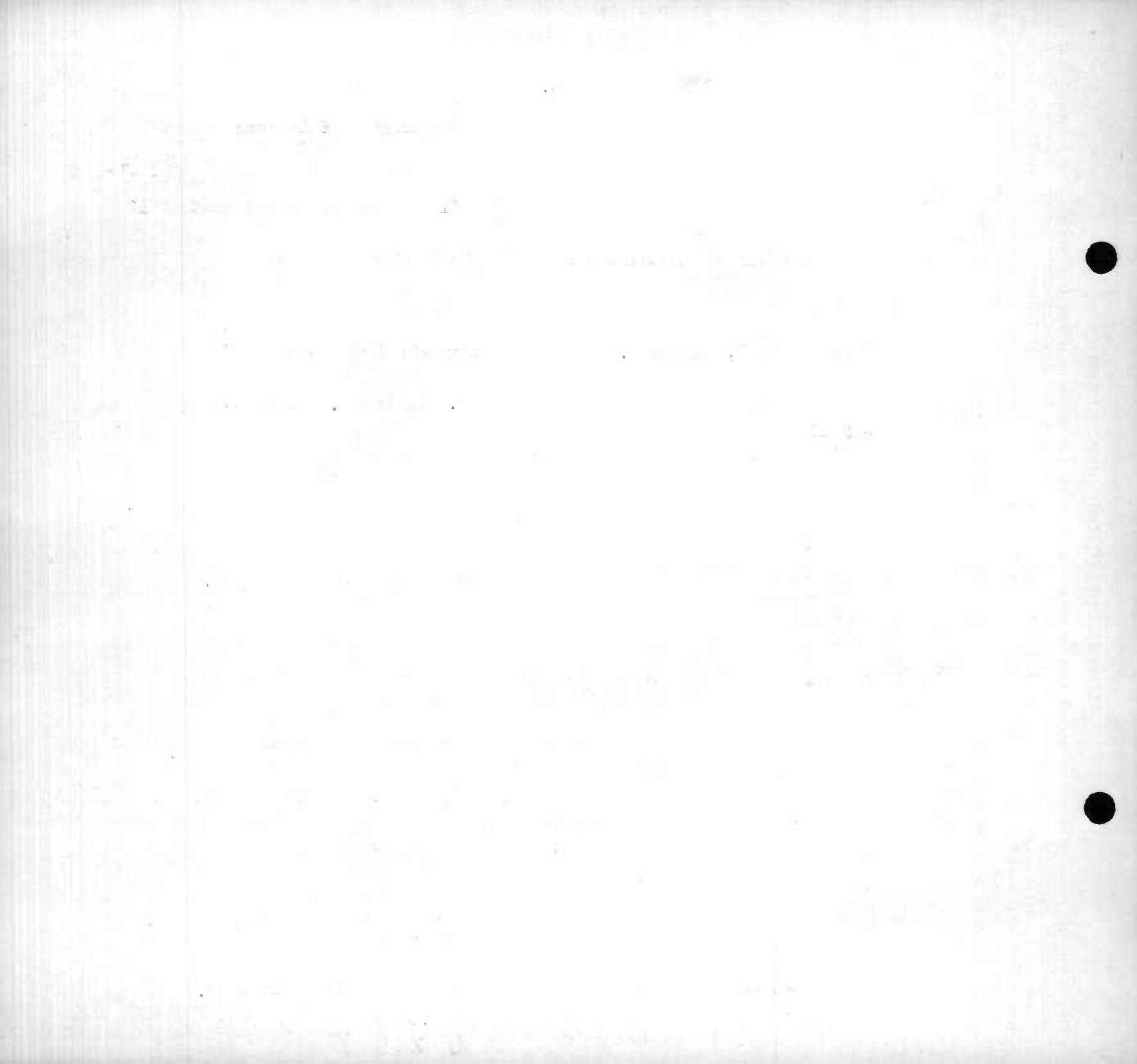
10-2-51

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 66 10194					CERTIFICATE OF DEATH					Registered No. 66 10194					
1. NAME OF DECEASED (Type or Print) <b>GALLACHER Mary E.</b>					2. DATE AND HOUR OF DEATH <b>Oct 8 - 1966 2:20 A.M.</b>										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bon Secours Hospital</b> <b>34</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Towson</b> D. STREET ADDRESS (If rural, give location) <b>214 A Rodgers Forge Road 12</b>										
5. SEX <b>F</b>		6. RACE <b>W-C</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>1-3-02</b>		9. AGE (In years lost birthday) <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>HINNANT, Elmore T.</b>					14. MOTHER'S MAIDEN NAME <b>Mary Z. HA Newsome</b>										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Mr. William V. Gallagher</b> ADDRESS <b>same address</b>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>metabolic acidosis</b> (A) DUE TO <b>chronic colonic fistula</b> (B) DUE TO <b>status post sigmoid resection for acute diverticulitis</b> (C) DUE TO <b>3 months</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION <b>7-11-66</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute + CHRONIC Diverticulitis</b>					20A. AUTOPSY? (Yes or No) <b>Yes</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>6-6-1966</b> to <b>10-8-1966</b> , that (I) (we) last saw the deceased alive on <b>10-8-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <b>Jorge B. Joaquin</b>										23B. DATE SIGNED <b>10-8-66</b>					
23C. PHYSICIAN'S NAME (Type) <b>JORGE B. JOAQUINO</b>										23D. ADDRESS <b>Bon Secours Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>10/11/66</b>					24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>					
										24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>					25C. FUNERAL DIRECTOR <b>Wm. J. Faldut &amp; Sons</b>					
										ADDRESS <b>Balto. Ind. Ave.</b>					





K-610

66 10195

BALTIMORE CITY HEALTH DEPARTMENT

66 10195

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GRACE H. KIRBY

2. DATE AND HOUR PRONOUNCED DEAD

10-8-66

8:30

a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Wesley Home  
2211 W. Rogers Ave.4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2211 W. Rogers Ave.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

6/8/1882

9. AGE (In years  
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George P. Holland

14. MOTHER'S MAIDEN NAME

Margaret Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

212-12-1430

17. INFORMANT

ADDRESS

The Wesley Home Records

18. CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-9-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/11/1966

23C. NAME of CEMETERY or CREMATORY

Greenmount Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

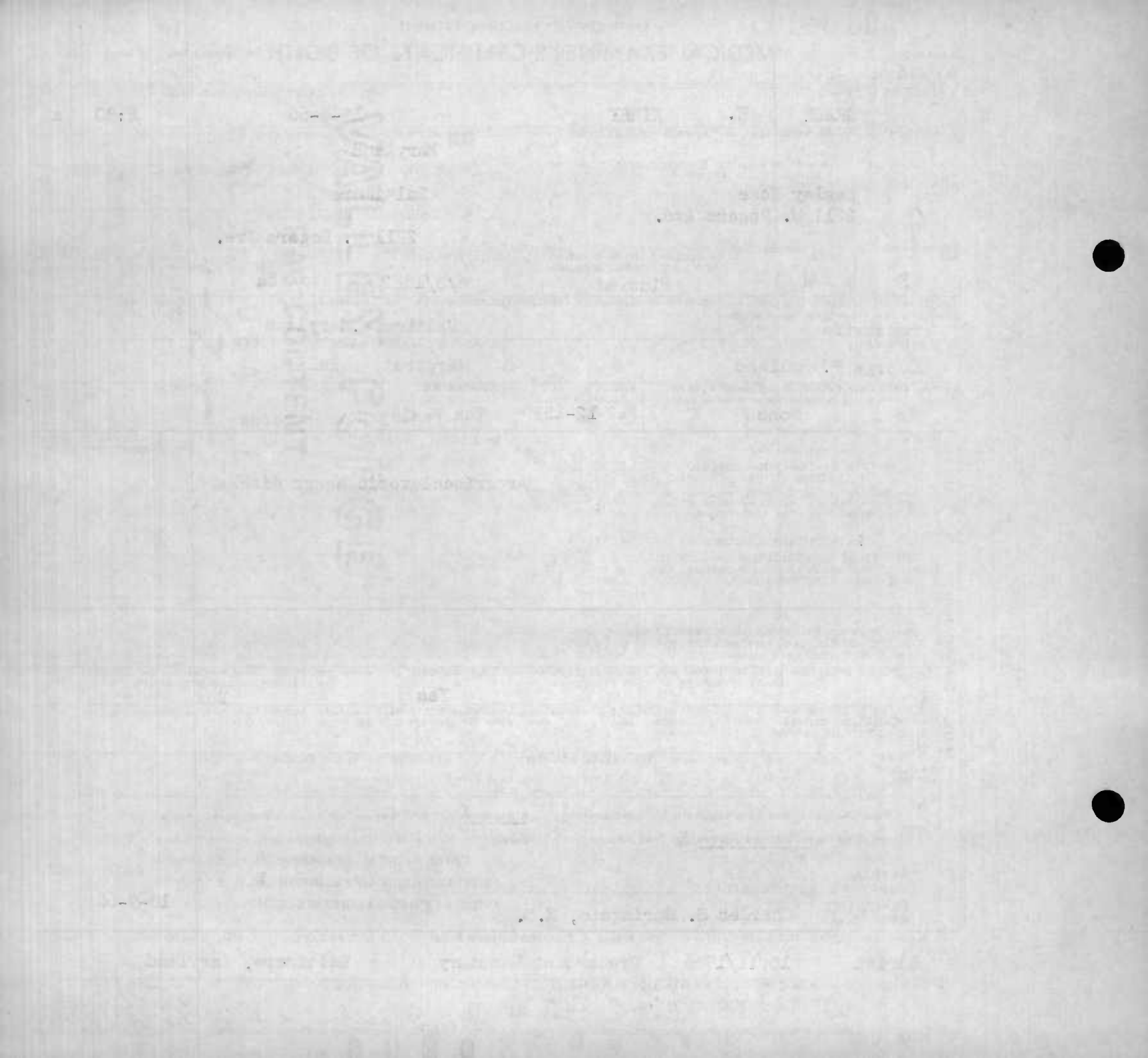
Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Wm J. Tubner &amp; Sons

ADDRESS

Baltimore, Md.  
North Pa.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10196</u>	
BIRTH NO. <u>66 10196</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WILLIAM VERNON WRIGHT, Sr.</u>		2. DATE AND HOUR OF DEATH <u>OCT. 5, 1966</u> <u>7:30 PM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>FRANKLIN SQUARE Hosp.</u> <u>36</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE #34</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-01</u> D. STREET ADDRESS (If rural, give location) <u>2611 MOORE AVE.</u>			
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 3, 1903</u>	9. AGE (in years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Maintenance Man</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM O. WRIGHT</u>			
14. MOTHER'S MAIDEN NAME <u>JULIA ZAIHER</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>HELEN M. WRIGHT</u> ADDRESS <u>2611 MOORE AVE - BALTIMORE, MD, 34</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>581.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>PULMONARY EDEMA, ACUTE 2</u> <u>CHF 2</u> <u>LIVER CIRRHOSIS, NUTRITIONAL, SEVERE</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>SEPT. 27, 1966</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PERITONITIS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <u>SEPT. 26</u> 19 <u>66</u> to <u>OCT. 5</u> 19 <u>66</u> , that (B) (we) last saw the deceased alive on <u>OCT. 5, 1966</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Milagrosa R. Calizo</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>OCT. 5, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>MILAGROSA R. CALIZO</u>		23D. ADDRESS <u>FRANKLIN SQUARE Hosp, BALTO, 23</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/10/66.</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>O. B. &amp; S. Faldema</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	
25D. ADDRESS					

Princeton University  
CH  
New Orleans, Louisiana

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10197				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10197	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JAMES V. MONROE</b>				2. DATE AND HOUR OF DEATH <b>10/9/66 1:30 AM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MD.</b>		B. COUNTY	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SUBURBAN COUNTRY CLUB</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>318 W. SARATOGA ST. 21201</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-12-08</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
13. FATHER'S NAME <b>Daniel Ridge Monroe</b>			14. MOTHER'S MAIDEN NAME <b>Mary Mudd</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>213-03-5234</b>		17. INFORMANT ADDRESS <b>Mrs. Margery S. Monroe same address</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Upper Gastrointestinal Hemorrhage</b>				CAUSE OF DEATH (A) <b>Upper Gastrointestinal Hemorrhage</b> (B) <b>Due to</b> (C) <b>Due to</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-3</b> <b>1966</b> to <b>10-9</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>10/9</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I) (we)</b> (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. Judith D. Gardner</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/9/66</b>	
23C. PHYSICIAN'S NAME (Print) <b>DR. JUDITH D. GARDNER</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Schumacher &amp; Sons</b>		ADDRESS <b>Baltimore, Md.</b>	

THE UNION PACIFIC RAILROAD

OF THE STATE OF CALIFORNIA



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10198</u>	
BIRTH NO. <u>66 10198</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH <u>10/7/66 (2 P.M.)</u> <u>2 P. M.</u>		
1. NAME OF DECEASED (Type or Print) <u>William C. ALBERT</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital.</u>			A. STATE <u>BALTO, MD</u>		
			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO, MD</u>		
			D. STREET ADDRESS (If rural, give location) <u>801 E BELVEDERE AVE</u>		
			<u>27-48</u>		
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>JULY 24 1907</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Md. Tobacco Growers</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM CLARENCE ALBERT</u>		14. MOTHER'S MAIDEN NAME <u>ADA MILLER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-1792</u>		17. INFORMANT <u>Mrs. Llewellyn Albert</u>	
				ADDRESS (Same)	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>3 days</u>		
			(B) <u>ASCUR Disease</u> <u>15 yrs</u>		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/5/66</u> 19 to <u>10/7/66</u> 19 that (I) (we) lost saw the deceased alive on <u>10/7/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>JH Cost</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>10/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>J H. COST, M.D.</u> M.O.				23D. ADDRESS <u>MERCY HOSPITAL</u>	
24A. BURIAL CREMATION, REMAINS (specify) <u>Burial</u>		24B. DATE <u>10/10/66.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fajana</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	





B-1520

66 10199

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10199

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT

S. BENESCH

BENESCH

2. DATE AND HOUR PRONOUNCED DEAD

October 7, 1966

11:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

9-22-1924

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF  
WHAT COUNTRY?

usa

13. FATHER'S NAME

ISADORE

14. MOTHER'S MAIDEN NAME

LEAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL  
SECURITY NO.

219-10-0862

17. INFORMANT

LEAH BENESCH

ADDRESS

2525 Eutaw Place

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/10/66

23C. NAME OF CEMETERY or CREMATORY

Bnai Israel

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Sydney S. Levinson

ADDRESS

3319  
Olympic Ave

VALLEY PROJECT

REPORT

NO

1951

1951

1951

1951

1951

1951

1951

1951

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10200		CERTIFICATE OF DEATH		Registered No. 66 10200	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM FRANKLIN HARRIS</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 4, 1966</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>37 MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4918 W. PRATT STREET 517 Cathedral St</b>					
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) -----		8. DATE OF BIRTH <b>2-6-1911</b>		9. AGE (In years last birthday) <b>55</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HARRIS</b>				14. MOTHER'S MAIDEN NAME <b>BERTHA WROTEN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>550-32-8351</b>		17. INFORMANT <b>HOSPITAL CHARTS</b>		ADDRESS	
18. <b>581.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>CARDIAC FAILURE</b> <b>PULMONARY CONGESTION</b> DUE TO (B) <b>ASCITES</b> DUE TO (C) <b>PORTAL CIRRHOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b> <b>1 week.</b> <b>7 years.</b>			
19A. DATE OF OPERATION <b>3 10/3/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PARACENTESIS</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Home Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> <b>19 66</b> to <b>10/4</b> <b>19 66</b> , that (I) (we) last saw the deceased alive on <b>10/4/66</b> <b>19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>James A. Guinlan Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/6/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>JAMES A. GUINLAN JR.</b>				23D. ADDRESS <b>Mercy Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-8-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD</b>		ADDRESS <b>4107 WILKENS AVENUE 21229</b>			

STATE OF TEXAS

COUNTY OF DALLAS

STATE OF TEXAS

COUNTY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of Dallas, Texas, this 1st day of May, 1901.

NOTARY PUBLIC

JOHN C. BROWN

My Comm. Expires 1st May 1902

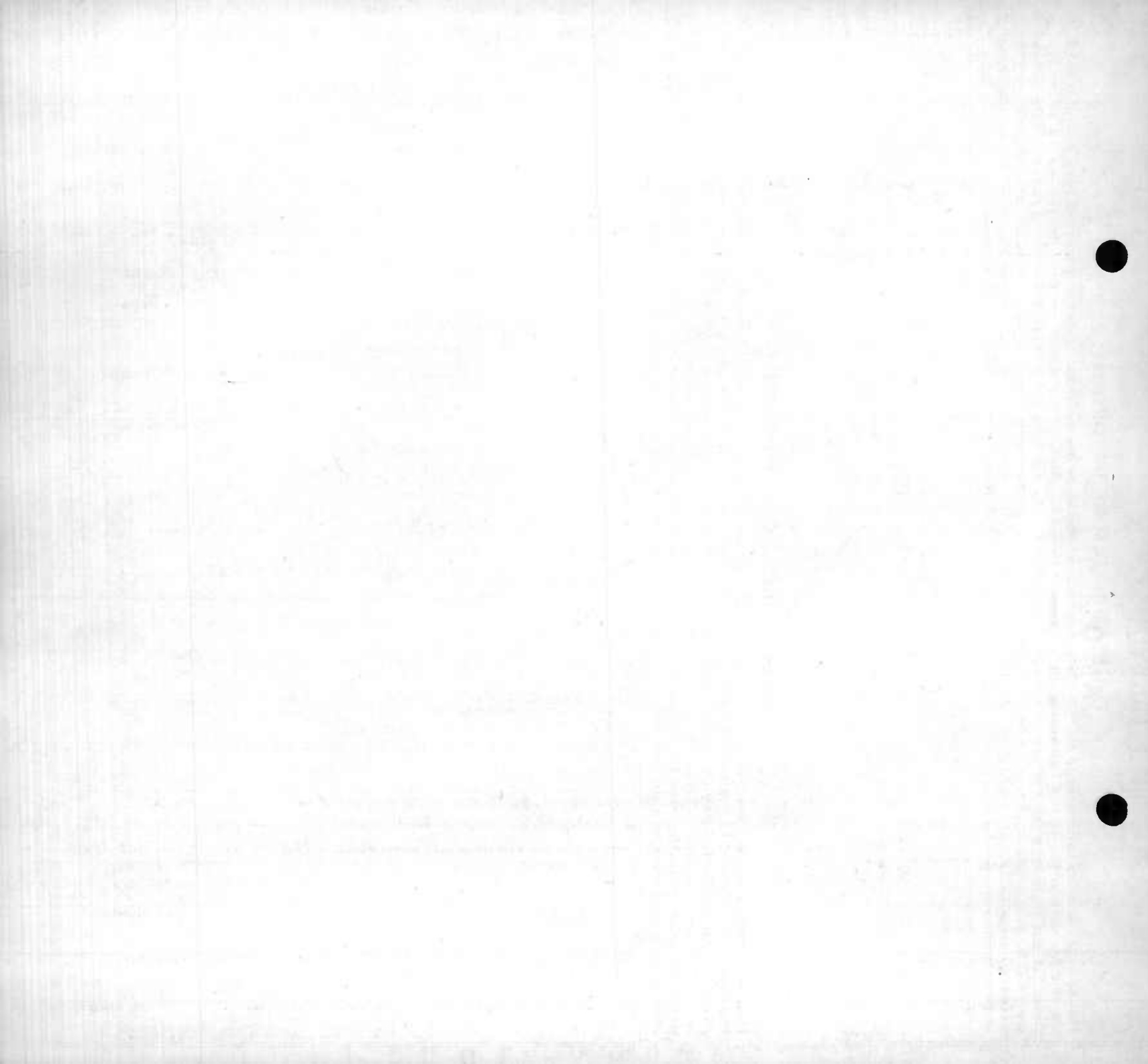
*[Signature]*  
John C. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10201		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10201	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Andrew Martini			2. DATE AND HOUR OF DEATH October 6, 1966		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1-02 D. STREET ADDRESS (If rural, give location) 3001 Eastern Ave.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Oct, 25, 1885	9. AGE (In years lost birthday) 80	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Highways		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albert Martini			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Elizabeth Zimmerman			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Elsie E. Warrell 2405 Pot Spring Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Myocardial Failure DUE TO ARTERIOSCLEROTIC DUE TO CARDIOVASCULAR RESISTANCE		
19A. DATE OF OPERATION None			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		
20A. AUTOPSY? (Yes or No) None			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? None		
22. I certify that (I) (this hospital) attended the deceased from Oct 2 1965 to Oct 6 1966, that (I) (we) last saw the deceased alive on Aug 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E.A. Schimunek			23B. DATE SIGNED 10-10-66		
23C. PHYSICIAN'S NAME (Type) E.A. Schimunek			23D. ADDRESS 842 S. East Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/10/66		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.			
25D. ADDRESS					

TO BE VERIFIED BY MEDICAL EXAMINER



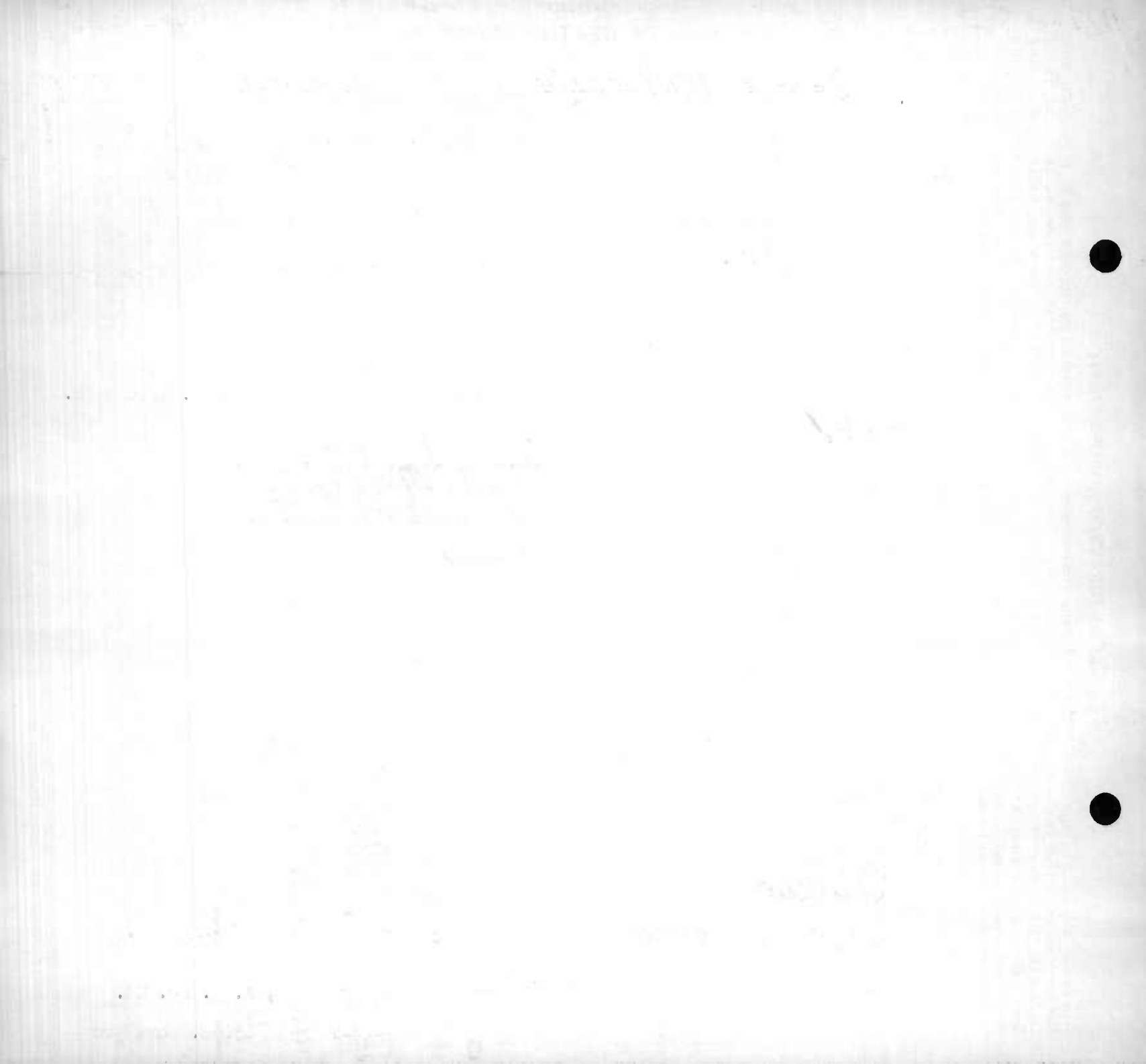


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10202	
BIRTH NO. 66 10202		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Dessie McKenzie</i>		2. DATE AND HOUR OF DEATH <i>10-6-66 1:55 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>23-01</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore # 21230</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>H3 South Baltimore General Hosp.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>124 W. Ostend St.</i>	
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>12-14-1904</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Ky.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>W. T. Elan</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Betty Dyson</i>	
ADDRESS <i>124 W. Ostend St.</i>					
18. <i>436X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Septicemic Suppur. Eryth. - lipid hepatitis - (M -) nephroses</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>diab. mellitus 2° bilateral therapy</i>			
		(C) <i>pneumonia</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <i>10-6-1966</i> to <i>10-6-1966</i> , that (we) lost saw the deceased alive on <i>10-6-1966</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. G. Arbellano</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10-6-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>ROBERTO G. ARBELLANO</i>		23D. ADDRESS <i>SOUTH BALTIMORE GEN. HOSP.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10 10 1966</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Uedar Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 11 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	
25C. FUNERAL DIRECTOR <i>Mc Cully</i>		ADDRESS <i>130 E. Fort Ave</i>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10203	
BIRTH NO. 66 10203		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Elridge Chaney		2. DATE AND HOUR OF DEATH Oct. 6, 1966 1:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 444 Union Memorial Hospital		A. STATE Md. B. COUNTY Baltimore			
5. SEX M		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 6/27/86		9. AGE (In years last birthday) 80		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Workman		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nathan Chaney		14. MOTHER'S MAIDEN NAME Prudence Cavey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-09-6393		17. INFORMANT Mona Moore	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO 1. Diabetes mellitus 2. Chronic Pyelonephritis (B) DUE TO (C) Bw		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from 9/21 1966 to 10/6 1966, that (I) <del>(was)</del> last saw the deceased alive on 10/6 1966 and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(was)</del> (did) (did not) view the body after death.					
23A. SIGNATURE Nat E. Watson, Jr. M.D.		23B. DATE SIGNED 10/6/66		23C. PHYSICIAN'S NAME (Type) NAT E. WATSON, JR., M.D.	
23D. ADDRESS THE UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 8, 1966		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Balto. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR Robert E. Farkley		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Balto, Md	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10204		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10204	
M.E. CASE NO.		PERRY		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BABY BOY PERRY		2. DATE AND HOUR OF DEATH 10/5/66 4:30 PM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. Hosp.		A. STATE MARYLAND B. COUNTY BALTO.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.		D. STREET ADDRESS (If rural, give location) UNIV. HOSPITAL 1607 LORMAN CT			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10/4/66	9. AGE (In years last birthday) 27	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A. - MD	
13. FATHER'S NAME WILLARD ALLEN		14. MOTHER'S MAIDEN NAME BEATRICE PERRY		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ELLIOT S. TOKAR MD	
18. 768.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) ASPIRATION PNEUMONIA (B) SEPTICEMIA (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 27 HOURS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. APNEA AT BIRTH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/4/66 19 to 10/5/66 19 that (I) (we) last saw the deceased alive on 10/5/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elliot S. Tokar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/6/66	
23C. PHYSICIAN'S NAME (Type) ELLIOT S. TOKAR		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Transit		24B. DATE 10-9-66		24C. NAME OF CEMETERY or CREMATORY Beachwood Cemetery	
24D. LOCATION (City, town, or county) Durham, N. Carolina		(State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fisk		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. 1735 Harford Ave. Balto., Md.	

1734

Released MEO per D. J. Smith  
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 10205					66 10205				
BIRTH NO.					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) <b>Perry, Beatrice</b>					2. DATE AND HOUR OF DEATH <b>10/4/66 6:10 PM M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>					A. STATE <b>Baltimore City - Maryland</b>				
(If not in hospital or institution, give street address or location)					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City 15-01</b>				
					D. STREET ADDRESS (If rural, give location) <b>1607 Lorman street</b>				
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>9-7-38</b>	9. AGE (In years last birthday) <b>28</b>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Lonnie Perry</b>			14. MOTHER'S MAIDEN NAME <b>Opeacher Hicks</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SPECIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT <b>Perry, Beatrice</b>			
18. <b>648.2.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Septic Shock</b>			CAUSE OF DEATH <b>Septic Shock</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Amnionitis</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>10/4/66</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Post Partal Hemorrhage</b>			20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>James F. Smith</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/4/66</b>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		24B. DATE <b>10-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Beachwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Durham, N. Carolina</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Marshall Jones, Jr., 1735 Harford Ave. Balto., Md.</b>					

Barney, Barney

10/1/68

Baltimore City - Highland  
Baltimore City  
1601 Lombard Street

University Hospital

Barney, Barney

9-7-68

North Carolina

Barney, Barney

Barney, Barney

Barney, Barney

10/1/68

Barney, Barney

Barney, Barney



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10206		Certificate of Death		Registered No. 66 10206	
1. NAME OF DECEASED (Type or Print) HEANEY, SR., CLEMENT THOMAS				2. DATE AND HOUR OF DEATH 10/05/66 16:15 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MARYLAND 21229				A. STATE MARYLAND 21223					
(If not in hospital or institution, give street address or location)				B. COUNTY					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
				D. STREET ADDRESS (If rural, give location) 2661 ST. BENEDICT STREET					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-12-90	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY BALTO. GAS & ELEC			11. BIRTHPLACE (State or foreign country) NEW BEDFORD MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN HEANEY			14. MOTHER'S MAIDEN NAME MASSABET WHELAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 212-05-5222			17. INFORMANT MRS. MARY HEANEY, 2661 ST. BENEDICT			ADDRESS HOSPITAL SLIP /ST. AGNES HOSPITAL			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 156.2 I DUE TO (A) Right lower lobe pneumonia and extreme inanition (B) Metastatic carcinoma (C) To the liver				INTERVAL BETWEEN ONSET AND DEATH					
19. DATE OF OPERATION 2				20. AUTOPSY? (Yes or No) YES				21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 21, 1966 to OCTOBER 5, 1966, that (X) (we) lost saw the deceased alive on OCTOBER 5, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. Jimenez				23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type) M. JIMINEZ				23D. ADDRESS ST. AGNES HOSPITAL; BALTO, MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 10-10-66				24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY	
								24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229	





S-530

66 10207

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10207

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARTHA Anne

SMITH

2. DATE AND HOUR PRONOUNCED DEAD

October 4, 1966

7:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

CATONSVILLE

D. STREET ADDRESS (If rural, give location)

207 Kenwood Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

CHILD

8. DATE OF BIRTH

JANUARY 26, 1964

9. AGE (in years  
last birthday)

2-1/2

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CHILD

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OKLAHOMA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RODERICK C. SMITH

14. MOTHER'S MAIDEN NAME

OLIVIA R. SUTTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MR. RODERICK C. SMITH, 207 KENWOOD AVENUE

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Plant Poisoning  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Ingestion of Yew Berries  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Back Yard

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

207 Kenwood Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 4 '66 6:00P

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ate poison berries.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-7-66

23C. NAME of CEMETERY or CREMATORY

LOUDON PARK CEMETERY

23D. LOCATION

(City, town, or county)

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD, 4107 WILKENS AVENUE

VALLEY FORD

RECEIVED

10

11

12

13

14

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17

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19

20

21

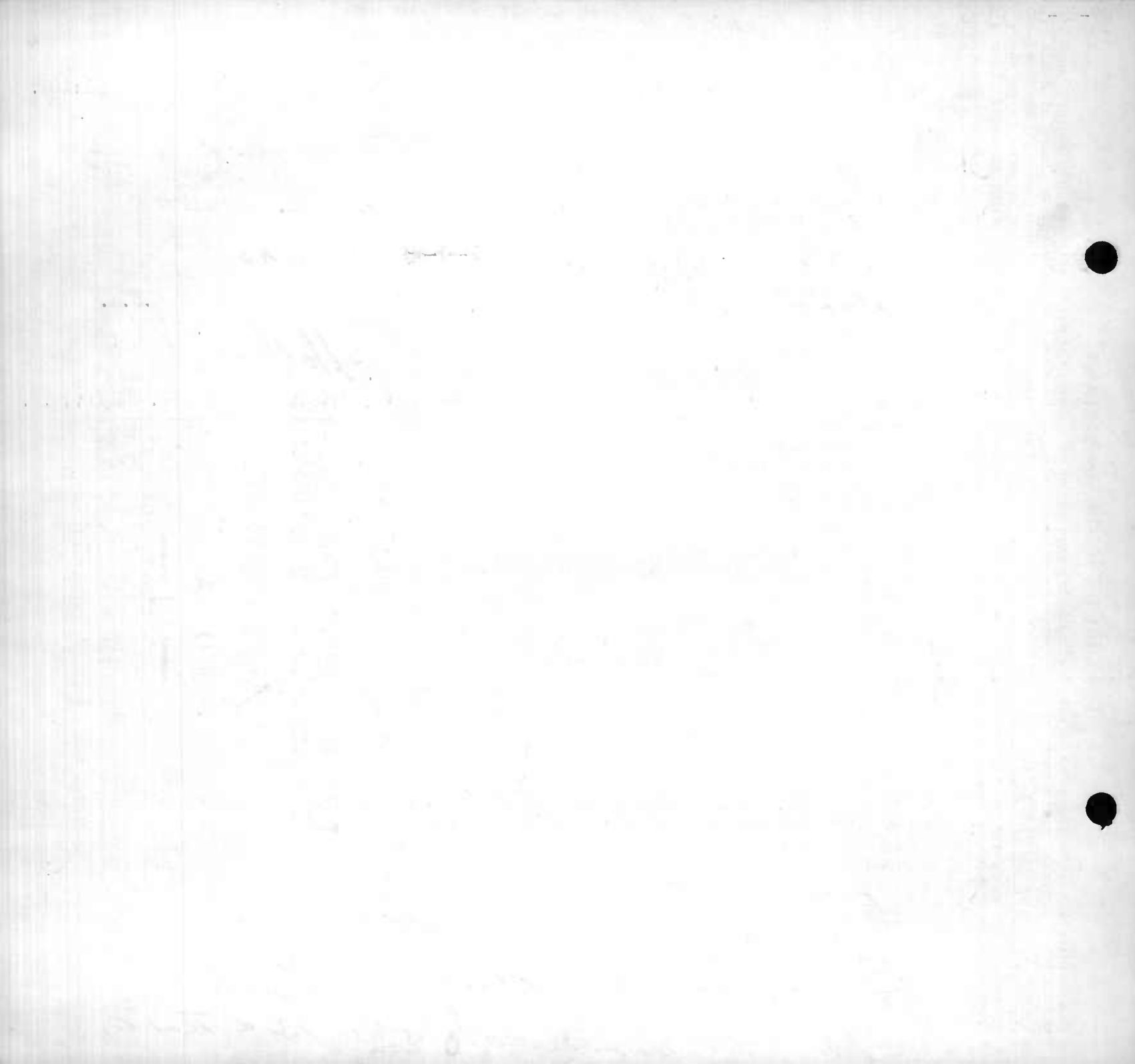
22

23

24

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10208		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10208	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Wanionek, Evelyn</u>		2. DATE AND HOUR OF DEATH <u>10-5-66 1:40 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
17. FATHER'S NAME <u>CHARLES SCHULER</u>		14. MOTHER'S MAIDEN NAME <u>EVELYN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>RECORDS: BCH 4940 EASTERN AVE. BALTO., M.D.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>345X I</u>		CAUSE OF DEATH (A) <u>Pyelonephritis</u> (B) <u>AND DECUBITUS ULCER</u> (C) <u>Multiple Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>3 mo.</u> <u>6 yrs.</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Anemia</u>		2 mo.	
19A. DATE OF OPERATION <u>8-29-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Decubitus ulcer</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>July 25</u> 19 <u>66</u> to <u>Oct. 5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Eusebio C. Kao</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Oct. 5, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>EUSEBIO C. KAO</u>		23D. ADDRESS <u>4940 EASTERN AVENUE Baltimore City Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>		24B. DATE <u>10/10/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION (City, town, or county) (State) <u>Balti</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>McGuire</u>		ADDRESS <u>130 E. Foul Cr.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10209	
BIRTH NO. 66 10209		(MELVIN N.)		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILTON JARZYNSKI		2. DATE AND HOUR OF DEATH 10-10-66 12.30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give town) BALTIMORE			
33		D. STREET ADDRESS (If rural, give location) 2021 EASTERN AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 7-18-17	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY SCRAP CORP. OF AMERICA		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK JARZYNSKI		14. MOTHER'S MAIDEN NAME FRANCES SZCZESNIAK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2- 10-5-42		16. SOCIAL SECURITY NO. 218-01-6991		17. INFORMANT FRANK JARZYNSKI	
18. 581.0 I 2-5-46		CAUSE OF DEATH		ADDRESS 2021 EASTERN AVE. BALTO. MD. 21231	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Hepatic Cirrhosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Possible pulmonary emboli			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/19 19 66 to 10/10 19 66, that (I) (we) lost saw the deceased alive on 10/9/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lee J. Silver				23B. DATE SIGNED 10/10/66 12:30	
23C. PHYSICIAN'S NAME (Type) Lee J. Silver		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-13-66		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cim.	
24D. LOCATION Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR W. Fialkowski	
25C. FUNERAL DIRECTOR W. Fialkowski		25D. ADDRESS 2007 Eastern Ave.			

2. 1/2 inch

1/2 inch

1/2 inch

1/2 inch

1/2 inch

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10210	
BIRTH NO. 66 10210		CERTIFICATE OF DEATH		Registered No. 66 10210	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. KATIE R. SHAFFER		2. DATE AND HOUR OF DEATH OCTOBER 8, 1966 2 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 818 WEST 32ND. STREET		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21211 Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital		D. STREET ADDRESS (If rural, give location) 13-05			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 09-28-74	9. AGE (In years last birthday) 92	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Harry Taylor		14. MOTHER'S MAIDEN NAME Lucinda Jane Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-54-6194-T	17. INFORMANT Mrs. William I. Harper		ADDRESS 825 W 36th Street Baltimore Md. 21211
18. 545X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) pulmonary edema (B) narrowing of stomach pylorus (C) 41K. Bm.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 1 1966 to Oct. 8 1966, that (I) (we) last saw the deceased alive on Oct. 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Shen Sho Tseng		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-8-66	
23C. PHYSICIAN'S NAME (Type) SHEN-SHO TSENG		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10-12-66	24C. NAME OF CEMETERY or CREMATORY Woodlawn	24D. LOCATION (City, town, or county) (State) Woodlawn. Baltimore Md. 10/12/66		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Frank J. Seitz		25C. FUNERAL DIRECTOR 814 W 36th St	



1941 - 1942 - 1943

1944 - 1945

1946 - 1947

1948 - 1949

1950 - 1951

1952 - 1953

1954 - 1955

1956 - 1957

1958 - 1959

1960 - 1961

1962 - 1963

1964 - 1965

1966 - 1967

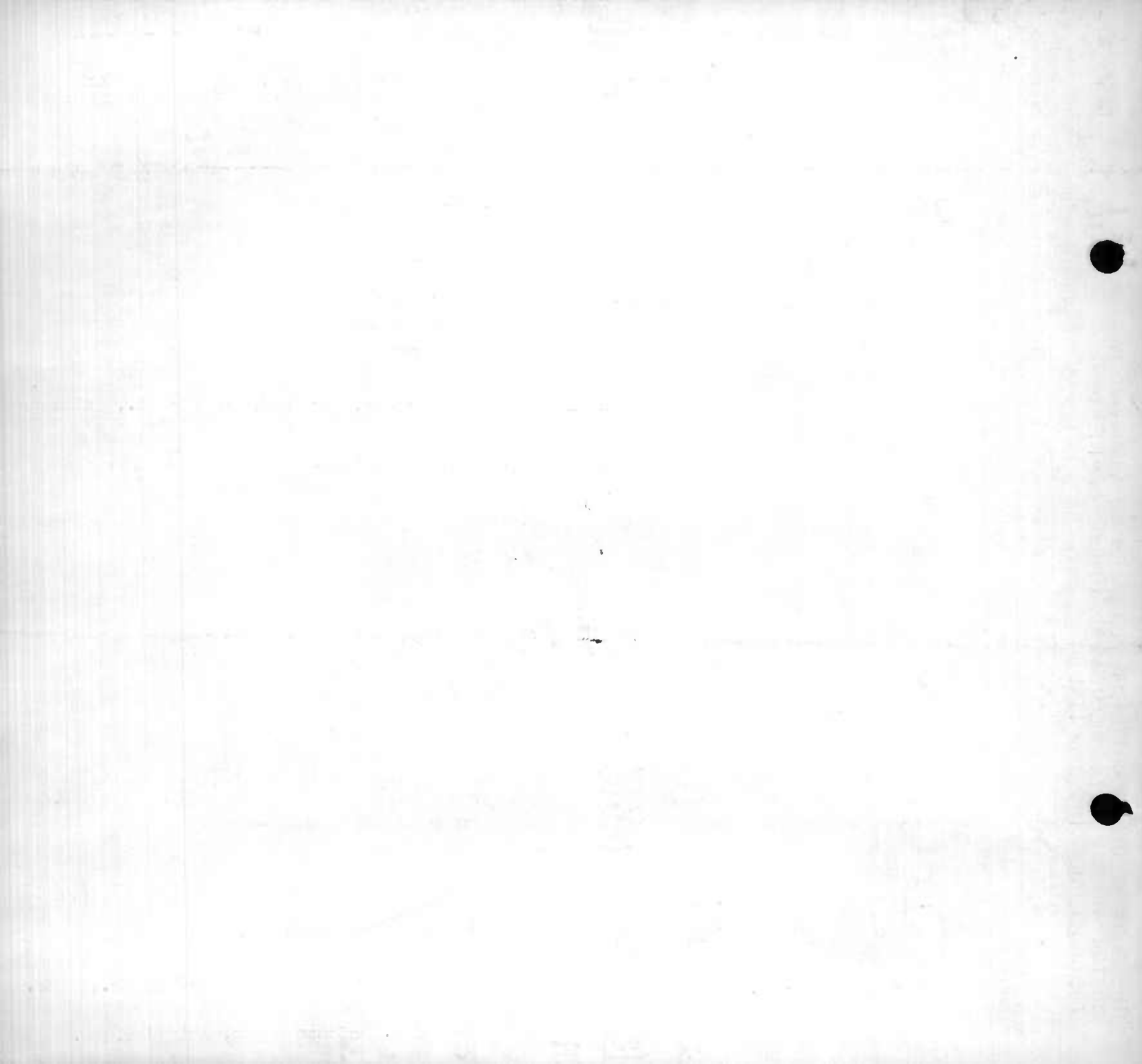
1968 - 1969

1970 - 1971

THE BODY OF JAMES WHITE WAS RELEASED ON APPROVAL BY  
DOCTOR HIRSCH OF THE MEDUNERAL DIRECTOR: IMPORTANT

THE MEDICAL EXAMINER'S REPORT: The body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10211				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10211	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) James White				2. DATE AND HOUR OF DEATH Oct 8, 1966 3:45 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY HARFORD Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BRADSHAW 62-00			
D. STREET ADDRESS (If rural, give location) 1500 Manchester Road							
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 2-15-98	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-28-6633		17. INFORMANT Helen Waters, 615 West Lanvale St., Baltimore		ADDRESS Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) myocardial failure Aspiration pneumonia, acute renal failure, 6m neg. sepsis 2 1/3° Burns				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 20		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Harford County 62-00			
21D. TIME OF INJURY (APPROX.) Sept. 6, 1966 7:00 pm		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Burned while lighting cigarette			
22. I certify that (I) (this hospital) attended the deceased from Sept 6, 1966 to Oct 8, 1966, that (I) (we) last saw the deceased alive on Oct 8, 1966 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Eugene Mezzi, M.D.				23B. DATE SIGNED Oct 8, 1966			
23C. PHYSICIAN'S NAME (Type) EUGENE MEZZI				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 11, 1966		24C. NAME OF CEMETERY or CREMATORY Community Baptist Cemetery		24D. LOCATION (City, town, or county) (State) Joppa Harford Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. Oct 11 1966		25B. NAME OF REGISTRAR Howard K. McComas & Son, Abingdon, Md.		25C. FUNERAL DIRECTOR ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10212		CITY HEALTH DEPARTMENT		Registered No. 66 10212	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Marian Tapp</b>		2. DATE AND HOUR OF DEATH <b>10/8/66 7:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		A. STATE <b>Maryland</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>2113 East Federal Street 21213</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12-18-1927</b>	9. AGE (In years last birthday) <b>38</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Wit Smullen</b>			
14. MOTHER'S MAIDEN NAME <b>Grace Cephas</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>204.3 I</b>		CAUSE OF DEATH <b>Acute blastie leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Anemia, Thrombocytopenia, leukopenia</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/19/66</b> to <b>10/8/66</b> that (I) (we) last saw the deceased alive on <b>10/8/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Craig A. Johanson</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CRAIG A. JOHANSON</b>		23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland Baltimore City Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 12, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Reid's Grove Cemetery</b>	
24D. LOCATION <b>Near Vienna, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Md.</b>			

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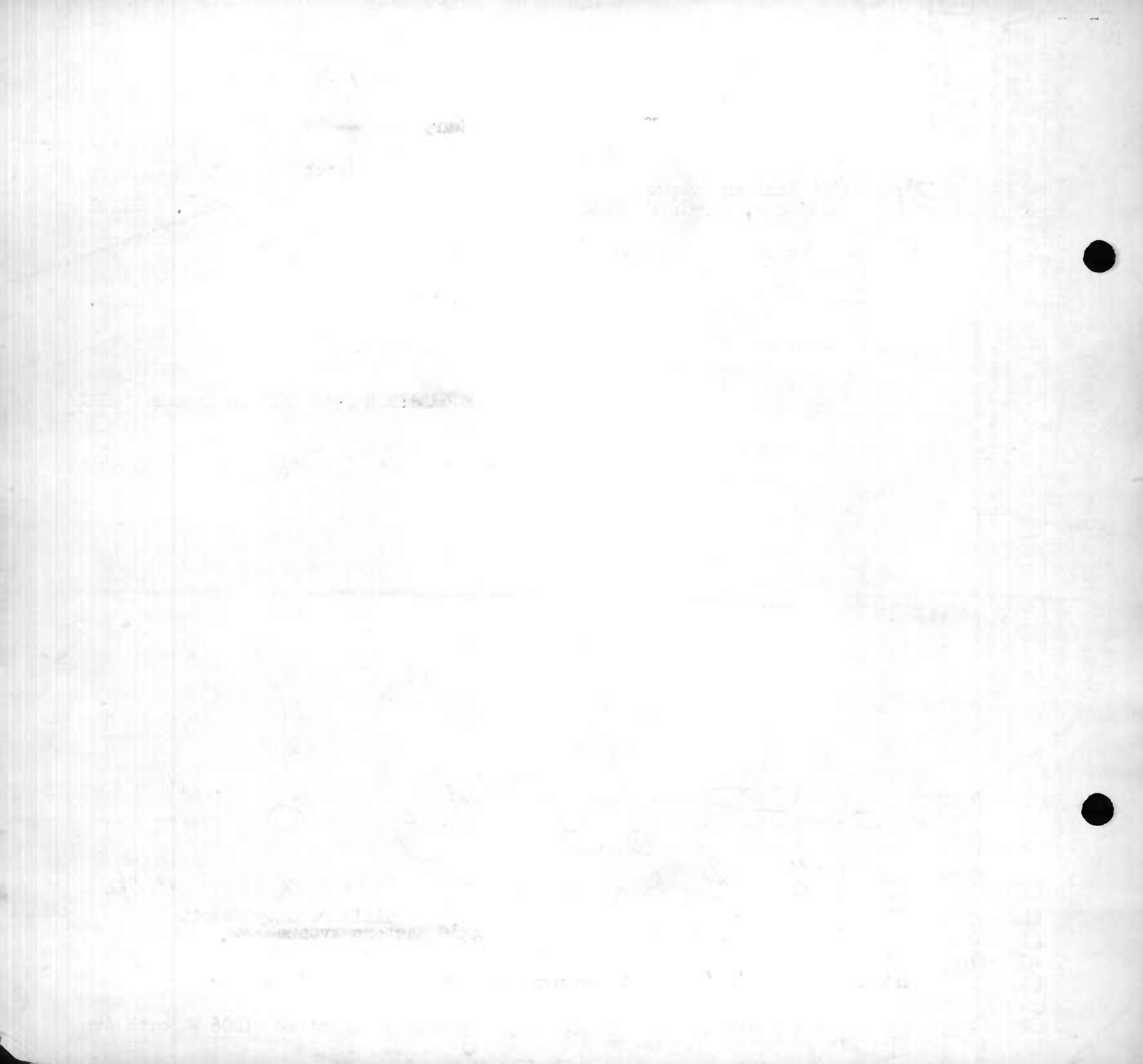
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10213		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10213	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ARMSTEAD, ESTELLE</b>		2. DATE AND HOUR OF DEATH <b>10/9/66 11 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALT. CITY HOSPITAL</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>4-02</b>		D. STREET ADDRESS (If rural, give location) <b>734 W FAYETTE ST. 21201</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>6/11/08</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LEWIS MOORE</b>		14. MOTHER'S MAIDEN NAME <b>LOTTIE ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>	
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Epidemioid Ca of Esophagus</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>8/3</b> 19 <b>66</b> to <b>10/9</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>10/9</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Allen Ginsberg</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLEN GINSBERG</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>BALT. Md 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25D. ADDRESS <b>1206 W North Ave</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10214</u>	
BIRTH NO. <u>66 10214</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>James Ennis</u>		2. DATE AND HOUR OF DEATH <u>10-10-66</u>   <u>5:50 a.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>4312 Dewey Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1-6-87</u>	9. AGE (In years last birthday) <u>79 yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired- B&amp;O R.R.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Ennis</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Conway</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-03-4519</u>		17. INFORMANT <u>Mrs. Fannie Ennis (Wife)</u>	
				ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>592X1</u>		CAUSE OF DEATH (A) <u>RENAL INSUFFICIENCY</u> DUE TO (B) <u>ESSENTIAL HYPERTENSION</u> DUE TO (C) <u>CHRONIC NEPHRITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9/24/66</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>UREMIA.</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>September 24, 1966</u> to <u>October 10, 1966</u> , that (I) (we) lost saw the deceased alive on <u>October 10, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gilbert L. Banfield</u>		M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Gilbert Banfield, M.D.</u>		23D. ADDRESS <u>722 N. Fulton Ave. Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-13-66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1966</u>		25B. NAME OF REGISTRAR <u>G. E. Farkema</u>		25C. FUNERAL DIRECTOR <u>George Kelson</u>	
				ADDRESS <u>1348 Calhoun St.</u>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10215

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

INEZ

BUNCH

2. DATE AND HOUR PRONOUNCED DEAD

October 10, 1966

1:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1103 Woodyear Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1103 Woodyear Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7-2-03

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Spriggs

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

219-30-9566

17. INFORMANT

ADDRESS

Lewis Bunch 1103 Woodyear Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-13-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem. Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 11 1966

G. L. G. Taylor, M.D.

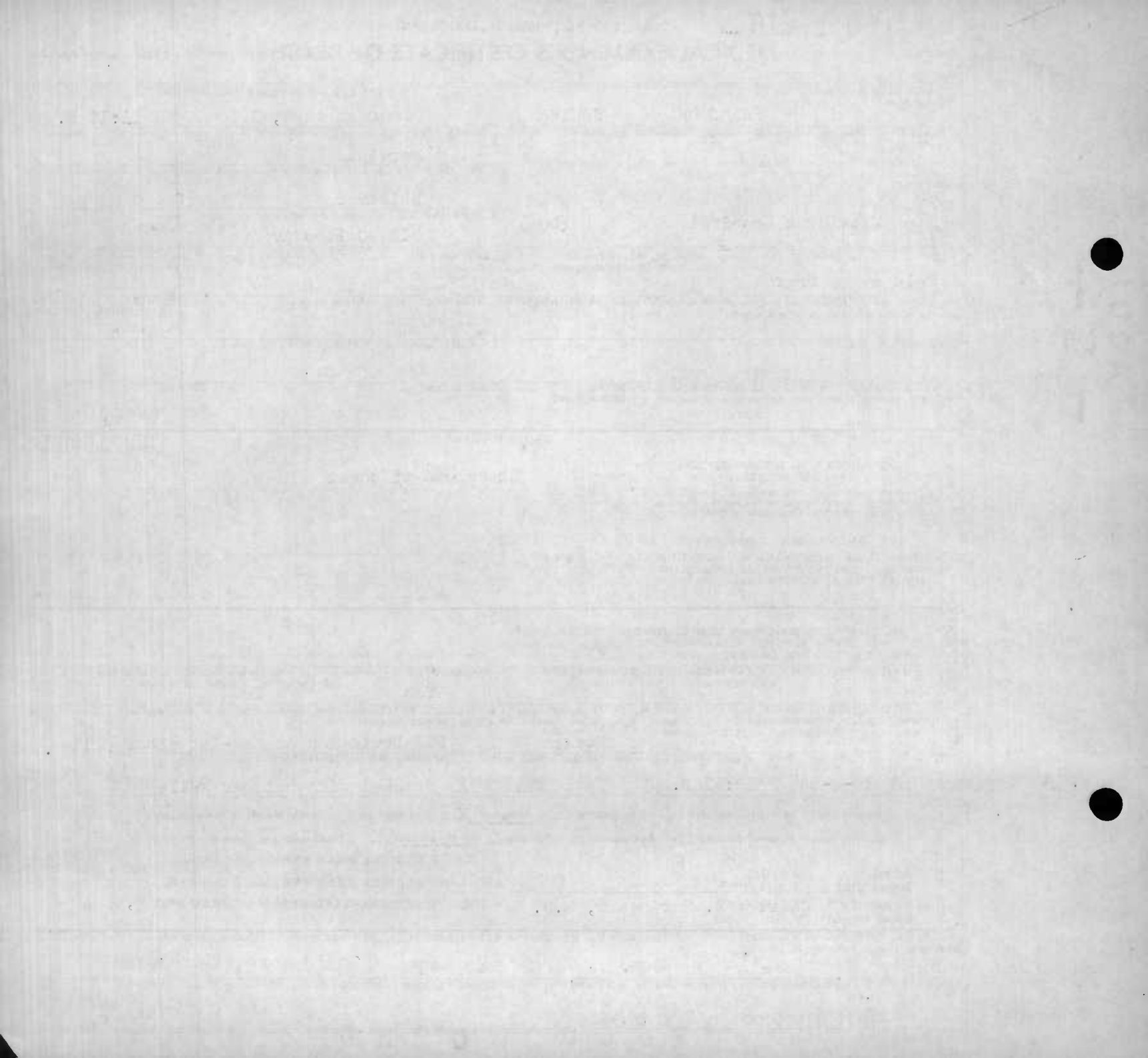
George Kelson 1348 N. Calhoun St.

WALLLEY PROFILES

REPORT

WALLLEY PROFILES







This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10217		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 10217</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>JOHN DALLAS, HEASLEY</b>			2. DATE AND HOUR OF DEATH <b>10-9-66</b> <b>2:00A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL CATON &amp; WILKENS AVE.</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21204 Balto. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1404 MARGARET AVE.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-9-26</b>	9. AGE (In years last birthday) <b>40</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WEST INGHOUSE</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ROBERT HEASLEY</b>			14. MOTHER'S MAIDEN NAME <b>RUTH KERR</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>159 202 151</b>	17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL RECORDS WILKENS &amp; CATON AVE.</b>		
18. <b>204.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO <b>Chronic Glomerulonephritis</b> (B) DUE TO <b>Gout, secondary to</b> <b>Polyarthritia Vera</b> (C) <b>Ch. Myelogenous Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>9-10</b> <b>19 66</b> to <b>10-9-66</b> <b>19 66</b> , that (I) (we) lost saw the deceased alive on <b>10-9</b> <b>19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manuel Jomenez</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>MANUEL JOMENEZ</b>			23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10, 12, 66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Zelienople</b>	24D. LOCATION (City, town, or county) (State) <b>Zelienople, Pa.</b>		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <b>OCT 11 1966 P. J. E. Johnson</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, Towson, Md.</b>			

Page 1 of 1

1. The first part of the document discusses the importance of maintaining accurate records of all transactions.

2. The second part of the document discusses the importance of maintaining accurate records of all transactions.

3. The third part of the document discusses the importance of maintaining accurate records of all transactions.

4. The fourth part of the document discusses the importance of maintaining accurate records of all transactions.

5. The fifth part of the document discusses the importance of maintaining accurate records of all transactions.

6. The sixth part of the document discusses the importance of maintaining accurate records of all transactions.

7. The seventh part of the document discusses the importance of maintaining accurate records of all transactions.

8. The eighth part of the document discusses the importance of maintaining accurate records of all transactions.

9. The ninth part of the document discusses the importance of maintaining accurate records of all transactions.

10. The tenth part of the document discusses the importance of maintaining accurate records of all transactions.

11. The eleventh part of the document discusses the importance of maintaining accurate records of all transactions.

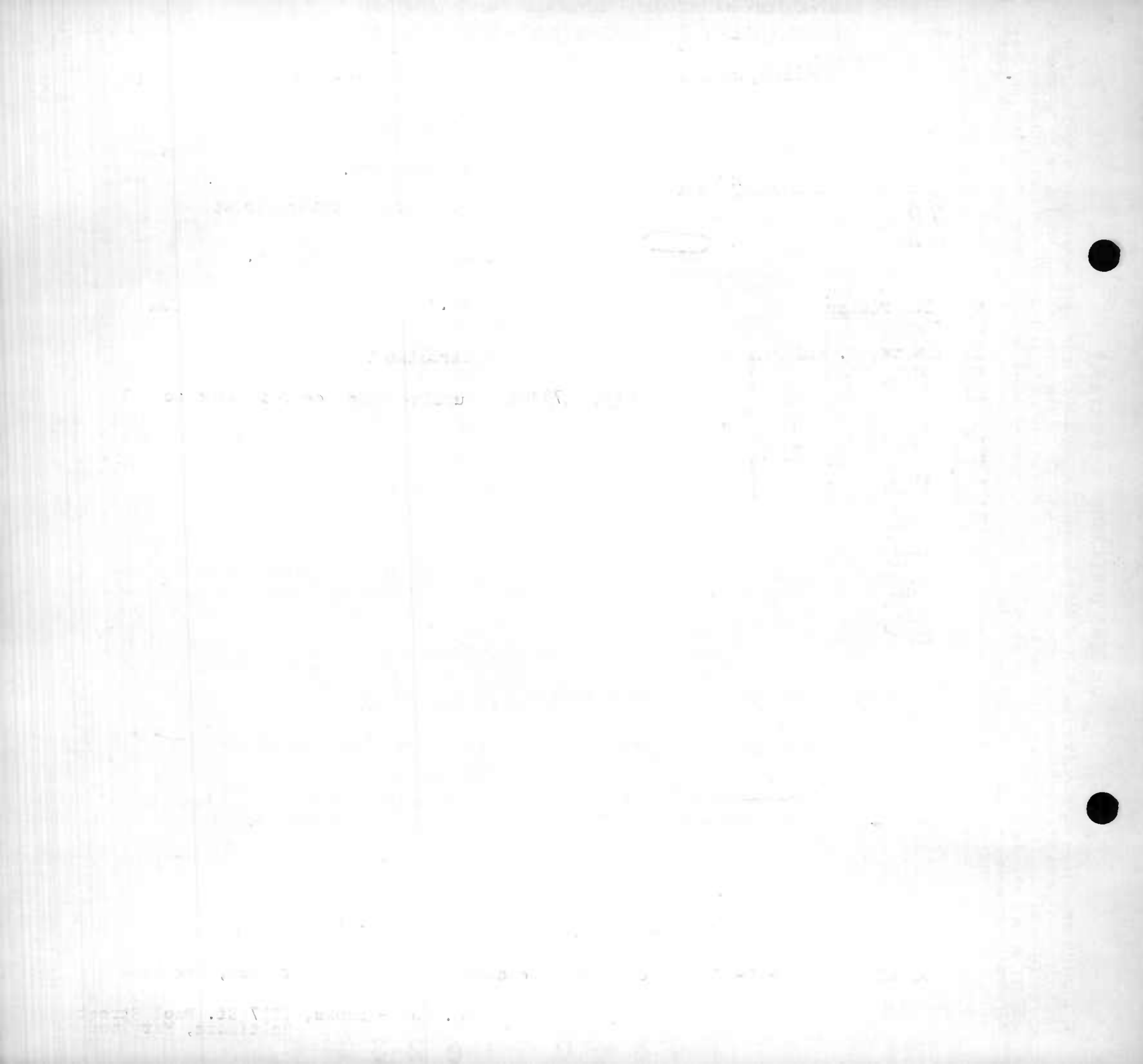
12. The twelfth part of the document discusses the importance of maintaining accurate records of all transactions.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

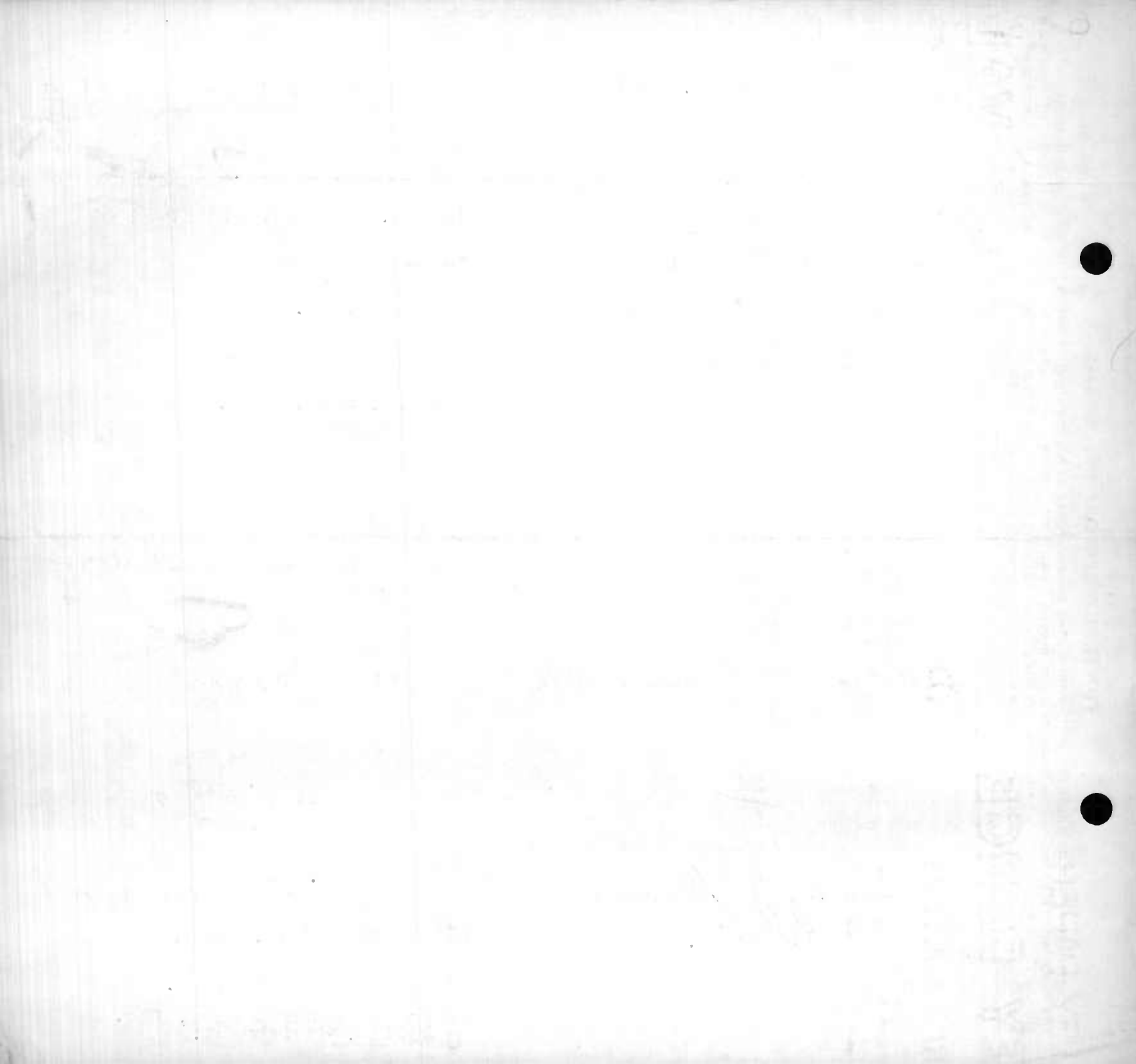
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10218</u>	
BIRTH NO. <u>66 10218</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>William, Ahlgren</u>		2. DATE AND HOUR OF DEATH <u>10-9-1966</u> <u>9:40</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Belton Hill Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, Md.</u> D. STREET ADDRESS (If rural, give location) <u>832 North Chester Street</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify)) <u>deceased</u>	8. DATE OF BIRTH <u>3/4/81</u>	9. AGE (In years last birthday) <u>85 yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>			11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Andrew, K. Ahlgren</u>			14. MOTHER'S MAIDEN NAME <u>Caroline ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-7390A</u>	17. INFORMANT ADDRESS <u>Nursing Home Records, Same as # 3</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASCD</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Malnutrition</u>					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>1 month</u>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>May 10 1966</u> to <u>October 9 1966</u> , that (I) <del>(lost)</del> last saw the deceased alive on <u>October 3 1966</u> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>Stanley Z. Felsenberg</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/11/66</u>
23C. PHYSICIAN'S NAME (Type) <u>STANLEY Z. FELSENBURG</u>			23D. ADDRESS M.D. <u>1129 E. Baltimore St Baltimore 2 Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-12-1966</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Felsenberg</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks, 1217 St. Paul Street Baltimore, Maryland</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10219		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10219	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Anna CLARA A. OPPITZ			2. DATE AND HOUR OF DEATH OCT 9 1966 1:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1808 E. MONUMENT STREET 21205		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-12-94	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME GEORGE SAUER			14. MOTHER'S MAIDEN NAME CATHERINE WALBECK WALDECK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Helen A. Oppitz, dght. above		
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) HYPOTENSION DUE TO (B) HYPOVOLEMIA DUE TO (C) EXTENSIVE ABDOMINAL CARCINOMATOSIS		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 1 DAY 9 MOS.
19A. DATE OF OPERATION 8/25/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CONSTRICTION ABDOMINAL MASS,		20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? PENDING
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 1 1966 to OCT 9 1966, that (I) (we) last saw the deceased alive on OCT 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy J. Gardner			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED OCT 9, 1966
23C. PHYSICIAN'S NAME (Type) TIMOTHY J. GARDNER			23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/11/66	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966	25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2001 E. Madison St.		



66 10220

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10220

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BERNARD E.

BANAHAN

2. DATE AND HOUR PRONOUNCED DEAD

October 7, 1966

7:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

00 54 S. Fulton Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

54 S. Fulton Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

6/30/98

9. AGE (In years  
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Government

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Francis P. Banahan

14. MOTHER'S MAIDEN NAME

Emma E. Pfeiffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

Yes

W. W. I

16. SOCIAL  
SECURITY NO.

218-23-0921

17. INFORMANT

ADDRESS

Leonora Dalton 3112 Lowview Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/12/66

23C. NAME OF CEMETERY or CREMATORY

Balto. National Cemetery, Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

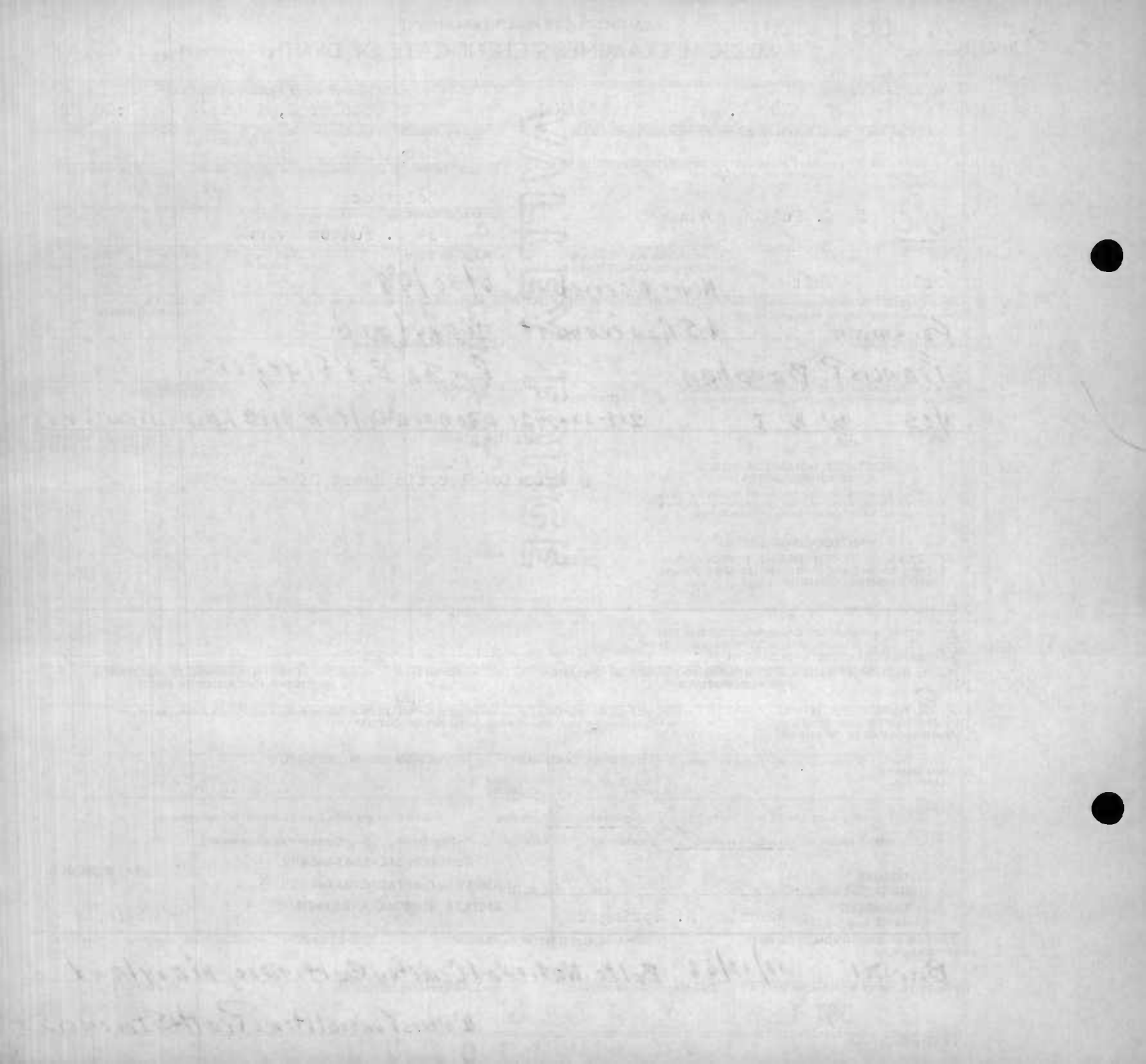
24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Walters Funeral Home Pratt &amp; Stricker St.

ADDRESS



F-364

66 10221

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10221

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM P. FEDERLINE

2. DATE AND HOUR PRONOUNCED DEAD

October 6, 1966 7:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)40  
99 St. Agnes Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

HOWARD Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore ELICOTT CITY 63-00

D. STREET ADDRESS (If rural, give location)

233 Chestnut Hill Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MARCH 29, 1908

9. AGE (in years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

OWNER

10B. KIND OF BUSINESS OR INDUSTRY

TRAILER BUILDER

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JOHN FEDERLINE

14. MOTHER'S MAIDEN NAME

MARY MULCAHY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William P. Federline 1732 Wilshire Ave

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 6, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-10-66

23C. NAME of CEMETERY or CREMATORY

Catholic Cem.

23D. LOCATION

(City, town, or county)

Baltimore Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

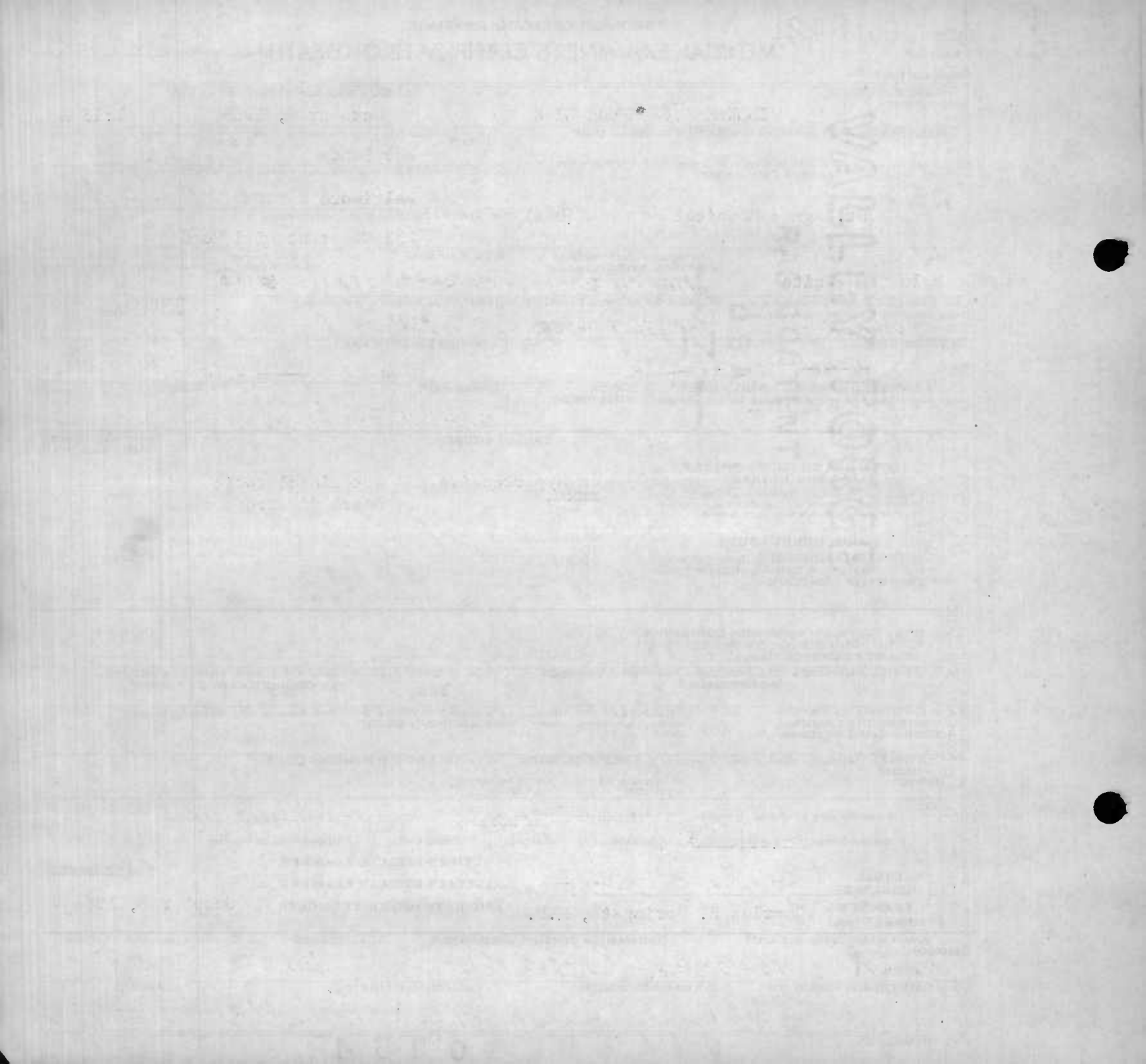
Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

J. J. Cunningham, Jr., Funeral Home, Inc.

ADDRESS







FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10222	
BIRTH NO. 66 10222		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>DOROTHY TOMLIN</b>		2. DATE AND HOUR OF DEATH <b>10/4/66 7 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>		D. STREET ADDRESS (If rural, give location) <b>1611 LANGFORD ROAD</b>		E. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. Co.</b> <b>33-00</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>2-23-16</b>	9. AGE (In years last birthday) <b>50</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECTY. - RET.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>ETCHER COLLINS</b>		14. MOTHER'S MAIDEN NAME <b>MARIE MORAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lloyd E. Tomlin - 1611 Langford Rd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>cardiac failure</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>anemia</b> <b>hurr cell and thrombocytopenia</b>		20. INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION		22. DATE OF OPERATION	
23. DATE OF OPERATION		24. DATE OF OPERATION		25. DATE OF OPERATION	
26. DATE OF OPERATION		27. DATE OF OPERATION		28. DATE OF OPERATION	
29. DATE OF OPERATION		30. DATE OF OPERATION		31. DATE OF OPERATION	
32. DATE OF OPERATION		33. DATE OF OPERATION		34. DATE OF OPERATION	
35. DATE OF OPERATION		36. DATE OF OPERATION		37. DATE OF OPERATION	
38. DATE OF OPERATION		39. DATE OF OPERATION		40. DATE OF OPERATION	
41. DATE OF OPERATION		42. DATE OF OPERATION		43. DATE OF OPERATION	
44. DATE OF OPERATION		45. DATE OF OPERATION		46. DATE OF OPERATION	
47. DATE OF OPERATION		48. DATE OF OPERATION		49. DATE OF OPERATION	
50. DATE OF OPERATION		51. DATE OF OPERATION		52. DATE OF OPERATION	
53. DATE OF OPERATION		54. DATE OF OPERATION		55. DATE OF OPERATION	
56. DATE OF OPERATION		57. DATE OF OPERATION		58. DATE OF OPERATION	
59. DATE OF OPERATION		60. DATE OF OPERATION		61. DATE OF OPERATION	
62. DATE OF OPERATION		63. DATE OF OPERATION		64. DATE OF OPERATION	
65. DATE OF OPERATION		66. DATE OF OPERATION		67. DATE OF OPERATION	
68. DATE OF OPERATION		69. DATE OF OPERATION		70. DATE OF OPERATION	
71. DATE OF OPERATION		72. DATE OF OPERATION		73. DATE OF OPERATION	
74. DATE OF OPERATION		75. DATE OF OPERATION		76. DATE OF OPERATION	
77. DATE OF OPERATION		78. DATE OF OPERATION		79. DATE OF OPERATION	
80. DATE OF OPERATION		81. DATE OF OPERATION		82. DATE OF OPERATION	
83. DATE OF OPERATION		84. DATE OF OPERATION		85. DATE OF OPERATION	
86. DATE OF OPERATION		87. DATE OF OPERATION		88. DATE OF OPERATION	
89. DATE OF OPERATION		90. DATE OF OPERATION		91. DATE OF OPERATION	
92. DATE OF OPERATION		93. DATE OF OPERATION		94. DATE OF OPERATION	
95. DATE OF OPERATION		96. DATE OF OPERATION		97. DATE OF OPERATION	
98. DATE OF OPERATION		99. DATE OF OPERATION		100. DATE OF OPERATION	

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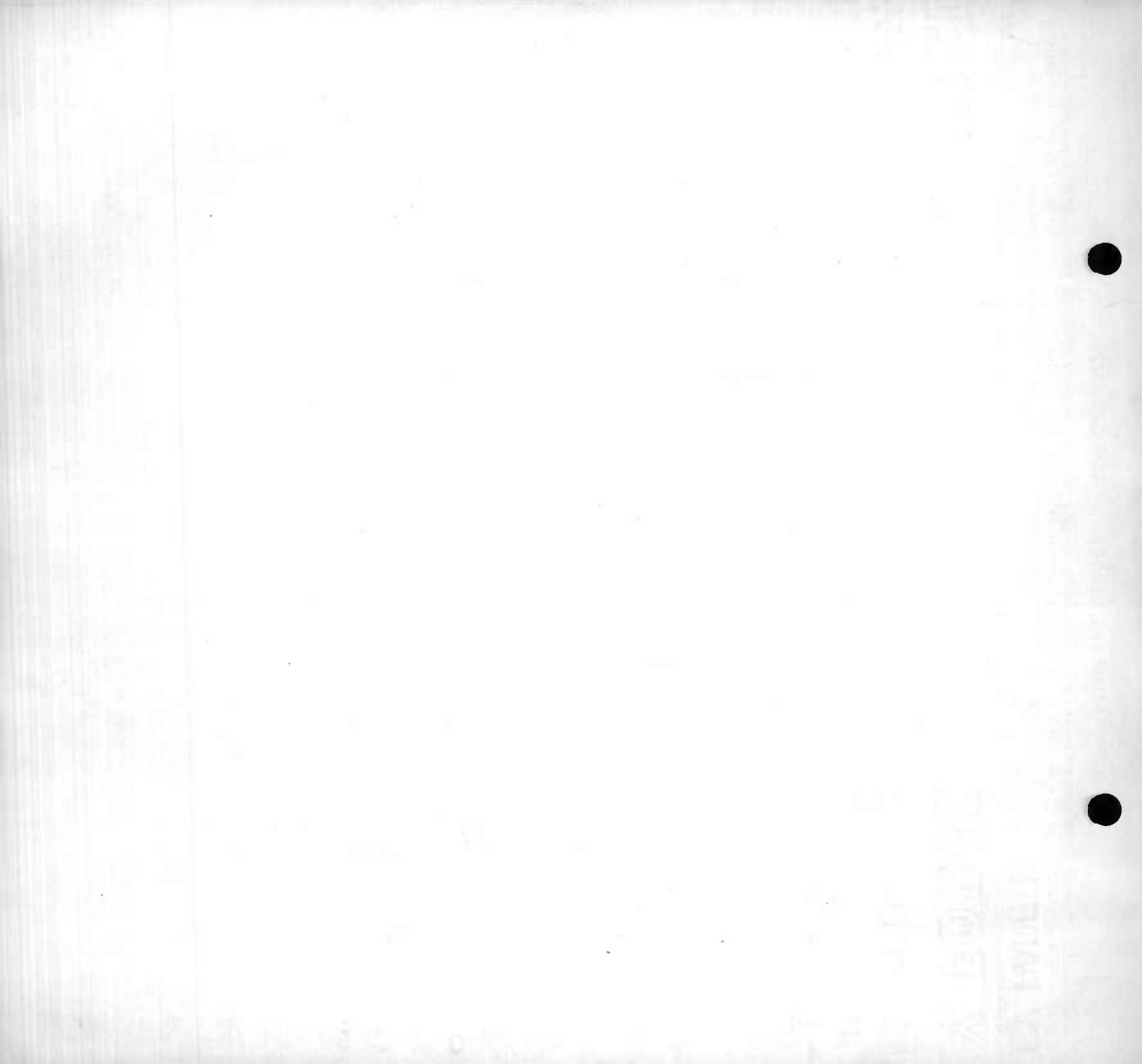
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10223		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10223	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl REDDY		2. DATE AND HOUR OF DEATH 10/6/66 9:31 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1320 N. MONTFORD AVE.	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 10/5/66	9. AGE (In years last birthday) 9	If Under 1 Yr. Months: 9 Days: 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME MINNIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 7730 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE		CAUSE OF DEATH (A) DUE TO Hyaline Membrane disease 30 hrs (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James B. Brayton		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/6/66	
23C. PHYSICIAN'S NAME (Type) JAMES B. BRAYTON		M.D. 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		23E. LOCATION (City, town, or county) (State)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATOR	
24D. LOCATION		24E. DATE		24F. LOCATION	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR R. B. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



D. 200

66 10224

BALTIMORE CITY HEALTH DEPARTMENT

66 10224

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GLADYS

DICKEY

2. DATE AND HOUR PRONOUNCED DEAD

October 8, 1966

10:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

837 N. Caroline Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

837 N. Caroline Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

May 30, 1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Beatrice Freeman 537 S 16th St. N. J.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

ii

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct 13/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cem

23D. LOCATION

(City, town, or county)

A. A. County Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

John P. Elicker 1129 N. Charles St

ADDRESS

Page 112

Mr.

Robert

Robert

Robert

Robert

Robert

Robert

Robert

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66 10225

BALTIMORE CITY HEALTH DEPARTMENT

66 10225

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HELEN (Helena) MITCHELL

2. DATE AND HOUR PRONOUNCED DEAD

October 7, 1966 1:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1022 Rutland Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separation

8. DATE OF BIRTH

Feb. 12, 1922

9. AGE (in years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lauriston N. Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Benjamin Williams

14. MOTHER'S MAIDEN NAME

Laura Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Benjamin Williams 1022 Rutland Ave

18.

452X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Ruptured intracranial saccular

(A) ~~Due to~~ aneurysm

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)   
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct. 12/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION (City, town, or county)

A. A. County Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Joseph T. Elisek 1129 N. Calhoun St

ADDRESS



(Name)

Residence  
Profession  
Education  
Latter M. C. C.  
Foster M. C. C.

5

6

Residence  
Profession  
Education  
Latter M. C. C.  
Foster M. C. C.



66 10226

BALTIMORE CITY HEALTH DEPARTMENT

66 10226

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BERNICE

PENN

2. DATE AND HOUR PRONOUNCED DEAD

October 5, 1966

8:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1800 E. Eager Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

2/12/21

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Myers

14. MOTHER'S MAIDEN NAME

Leticia Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Thomas Penn 1800 Rodman Ave

18. 916.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Extensive third degree burns  
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1800 E. Eager Street

21D. TIME  
OF INJURY  
(APPROX.)

September 17, 1966

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Dropped match while lighting cigarette

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 6, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct 11/66

23C. NAME of CEMETERY or CREMATORY

St Stephen Cem

23D. LOCATION

(City, town, or county)

(State)

Essex Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Fisher M.D.

24C. FUNERAL DIRECTOR

Milton E. Ellickson 11297 Carlin St

ADDRESS

John Meyer  
Bills. 100.00  
4/19/21  
Bills. 100.00

John Meyer  
Bills. 100.00

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10227		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10227	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>AGUSTUS STEVENSON</u>			2. DATE AND HOUR OF DEATH <u>10/5/66</u> <u>5<sup>45</sup></u> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mercy Hospital</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>10-02</u>		
			D. STREET ADDRESS (If rural, give location) <u>1001 Abbott St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>Aug 6, 1905</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ne.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sandy Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Lucy</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mamie Marshall</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>334X1Y260X</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>ENDOTOXIC SHOCK</u> DUE TO		<u>12 yrs</u>	
		(B) <u>URINARY TRACT INFECTION</u> DUE TO		<u>2-3 days</u>	
		(C) <u>STROKE</u>		<u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>DIABETES MELLITUS</u>		<u>YEARS</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>10/3</u> 19 <u>66</u> to <u>10/5</u> 19 <u>66</u> , that (1) (we) lost saw the deceased alive on <u>10/5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Bruce Gerber, M.D.</u> M.D.				23B. DATE SIGNED <u>10/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. BRUCE GERBER, M.D.</u> M.D.				23D. ADDRESS <u>8045 Woodgate Ct., BALTO., MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Oct 11/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1966</u>			
25B. NAME OF REGISTRAR <u>R. E. E. F.</u>		25C. FUNERAL DIRECTOR <u>Milton E. Elickson</u>			
25D. ADDRESS <u>1129 N. Carroll</u>					

the same page, 192 121

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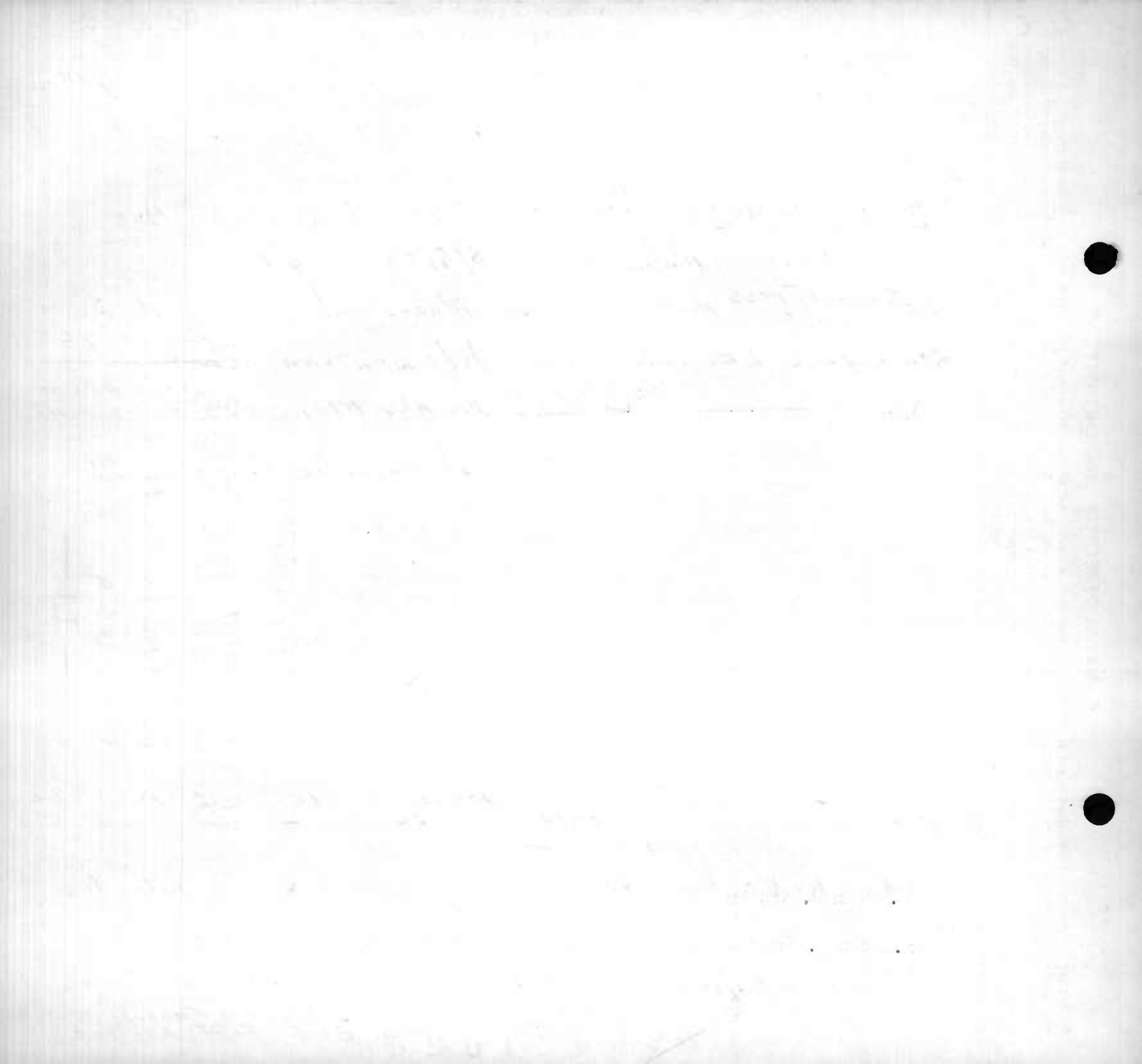
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no

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10228		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10228	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Wanda A. Sparra</i>		2. DATE AND HOUR OF DEATH <i>10/10/66 9:15 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 8-01</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>3413 Woodstock Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>8/9/05</i>	9. AGE (in years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Type in full) <i>Seamstress Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>American Golfer</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>STANISLAUS LEWANDOWSKI</i>			
14. MOTHER'S MAIDEN NAME <i>KLEMENTYNA ZANBRZYCKI</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>212-07-6701</i>		17. INFORMANT <i>MRS Alex KLEWICKI</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) <i>Cerebral-Vascular Accident ? hrs</i> (B) <i>DUE TO</i> (C) <i>DUE TO</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>10-10-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-10-66</i> to <i>10-10-66</i> , that (we) last saw the deceased alive on <i>10-10-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. John R. Vaughn</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. John R. Vaughn</i>		23D. ADDRESS M.D. <i>The Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/13/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 11 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc.</i>			
25D. ADDRESS <i>1501 East Fort Avenue</i>					



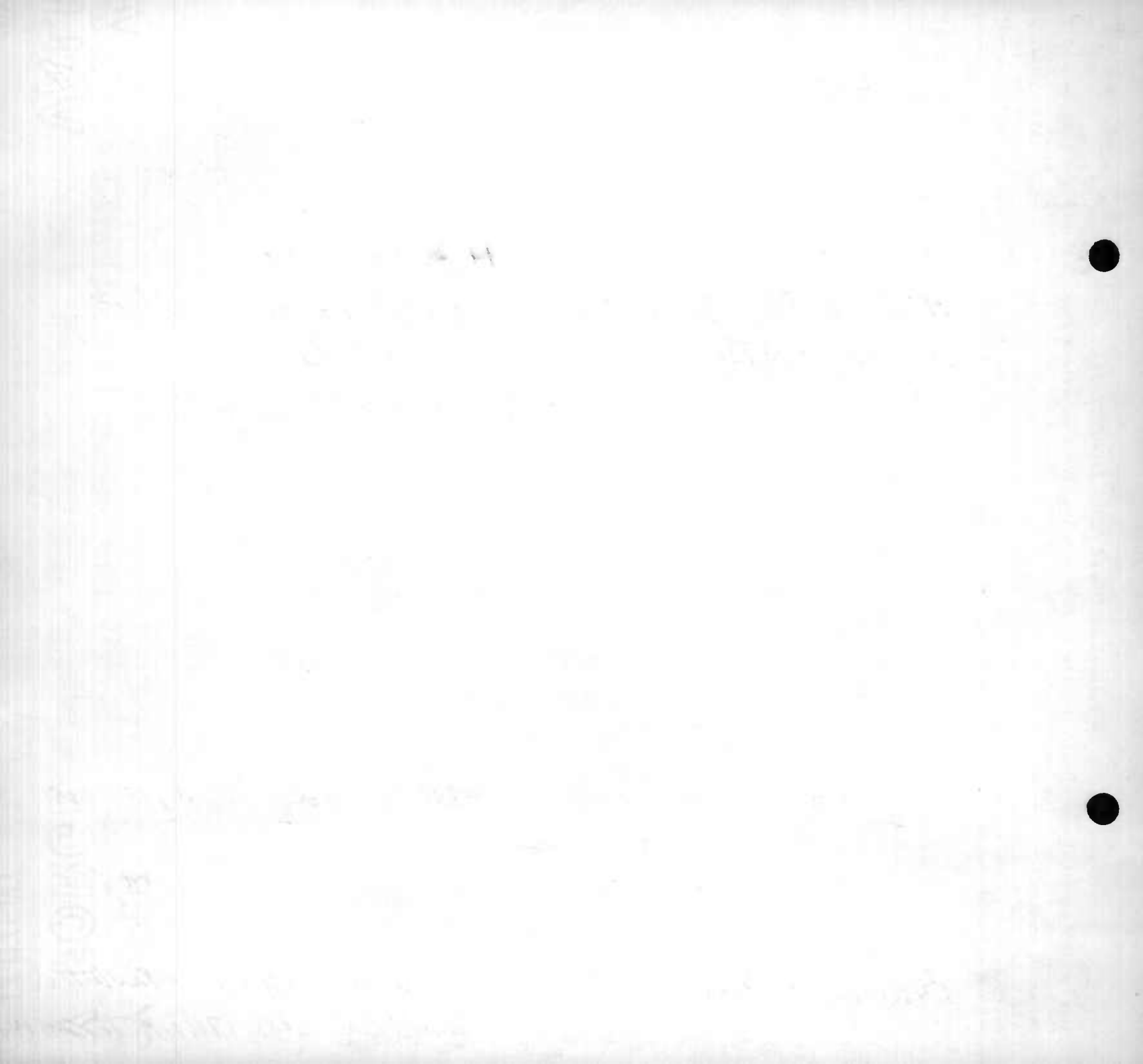


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10229				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10229	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Leon Henson</i>		2. DATE AND HOUR OF DEATH <i>10/10/66 11:15 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Md</i>		B. COUNTY <i>Maryland</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 2</i>				D. STREET ADDRESS (If rural, give location) <i>803 - Somerset St.</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>11-26-96</i>		9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>DANNIE PROCTOR</i>				14. MOTHER'S MAIDEN NAME <i>PROCTOR</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>220-141546</i>		17. INFORMANT <i>HARRIETT COLBERT</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma of Breast and Gram negative Sepsis</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>8/30</i> 19 <i>66</i> to <i>10/10</i> 19 <i>66</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>10/10</i> 19 <i>66</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <i>M. May 9. Kelly</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/10/66</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/15/66</i>		24C. NAME of CEMETERY or CREMATORY <i>MT. CALVARY CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>Snow Hill Rd MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Donald E. Glover</i>		25C. FUNERAL DIRECTOR <i>170/N PATTERSON PL</i>		ADDRESS	



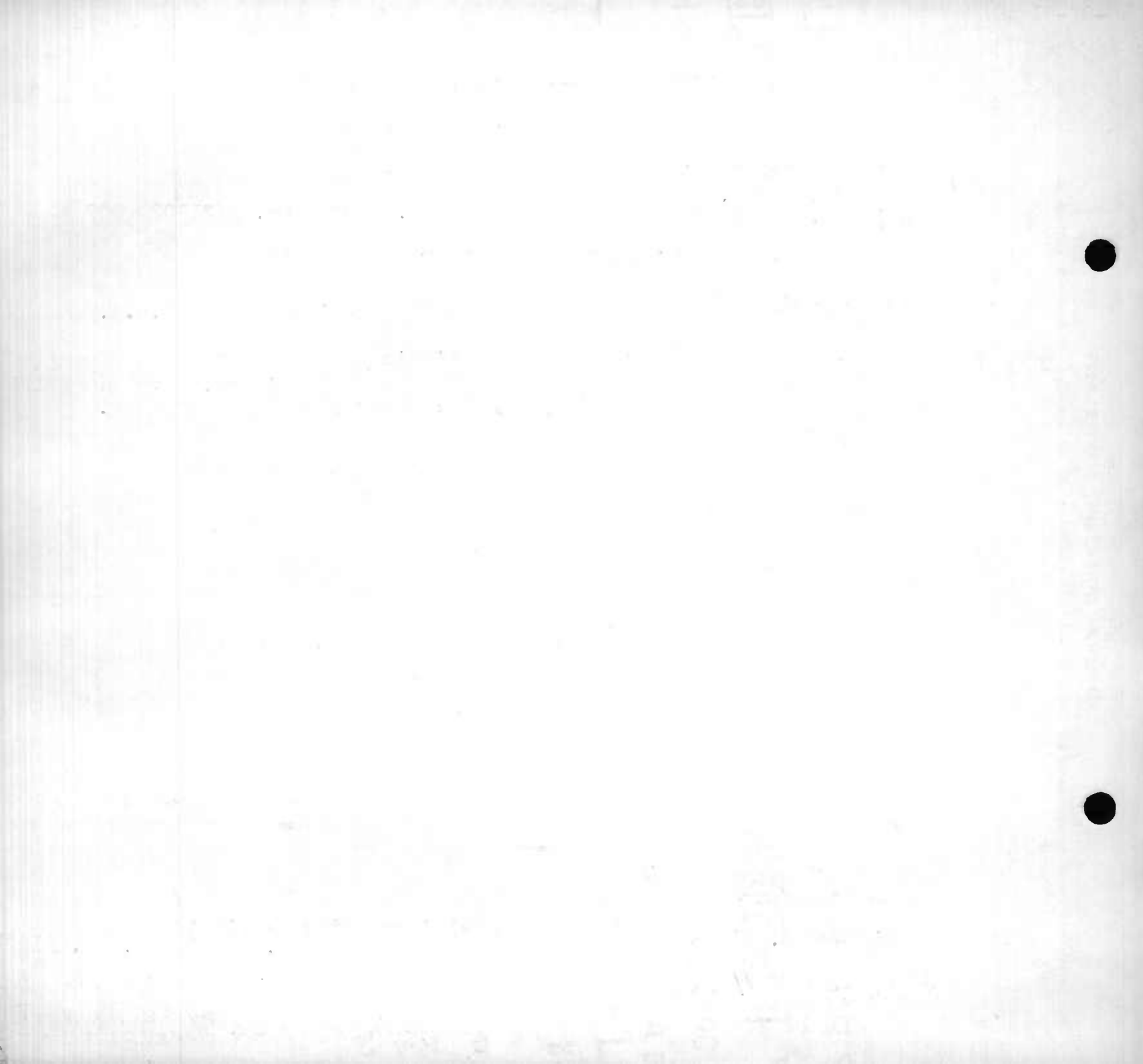


45-02-91ED  
T-46

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 10230		CERTIFICATE OF DEATH		66 10230	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Heard Taylor (AKA HENRY)		10-6-66 9:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1236 W. North Ave. #21202 007			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Negro	Widowed	1877	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
FARMER				South Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Sanko		Liddie		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217-54-441		Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
144X I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Squamous cell Carcinoma of Palate DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Severe Generalized Arteriosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3-20 1966 to 10-6 1966, that (we) last saw the deceased alive on 10-6 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Richard L. Bishop				10-6-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Richard L. Bishop				Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		10/11/66		JAMESTOWN BAPTIST	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 11 1966		GEO. E. FOLMAN JR.		GEORGE FOLMAN JR. 543 E. MAIN ST. MONCK'S CORNER SC	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOHN EARL

JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

October 10, 1966

11:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET

HOSPITAL OR

ADDRESS OR LOCATION)

12 N. Monroe Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

12 N. Monroe St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

May 12 1921

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

King &amp; Queen Co VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Jackson

14. MOTHER'S MAIDEN NAME

Mariah Jefferson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

228-07-7241

17. INFORMANT

Daisy Jackson

ADDRESS

12 N. Monroe St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-14-66

23C. NAME OF CEMETERY or CREMATORY

BALD. NAT.

23D. LOCATION

(City, town, or county)

(State)

BALD.

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 11 1966

MORTON + Dye II

1701 LAURENS

- 1- Army Discharge for John E. Jackson - from 5/12/21
- 2- Lt. Chauffeur License J 250-429-162-361 T for  
John Earl Jackson from 5/12/21

1  
W-240

66 10232

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 10232

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

AUSTIN

WESLEY

2. DATE AND HOUR PRONOUNCED DEAD

October 9, 1966

10:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

114 Monastery Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9-13-28

9. AGE (In years  
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

No

10B. KIND OF BUSINESS OR INDUSTRY

STEEL

11. BIRTHPLACE (State or foreign country)

Blackstone, VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wesley Austin SR.

14. MOTHER'S MAIDEN NAME

Mildred Royal

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Y

16. SOCIAL  
SECURITY NO.

227-32-8852

17. INFORMANT

Louise Hicks

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bilateral Bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Fatty Metamorphosis of Liver  
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes - Partial

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-13-66

23C. NAME OF CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

BALTO.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

MORTON &amp; DYE

ADDRESS

1701 LAURENS

VALLEY HILL

100-1000000

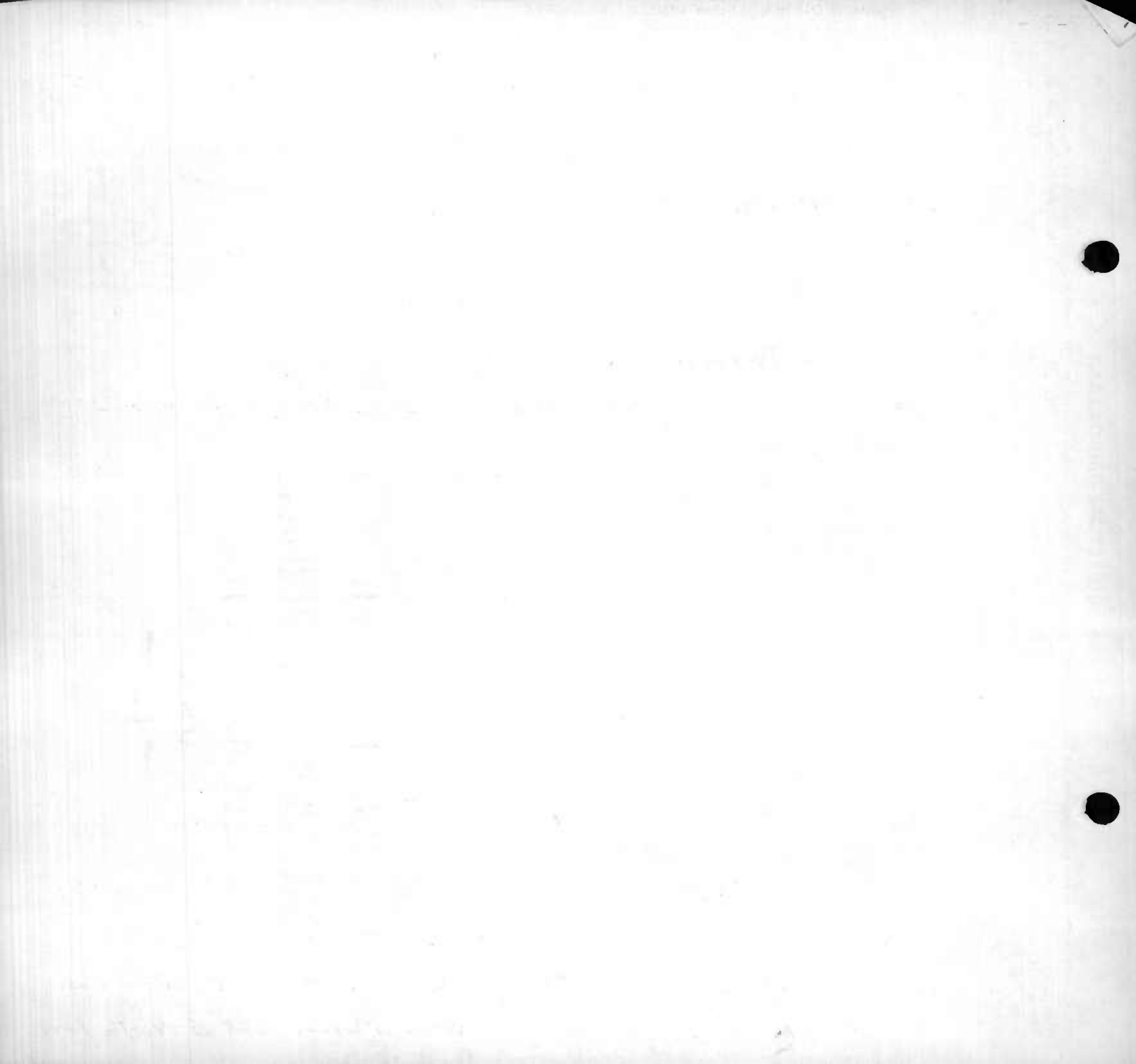


## CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10233		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>THOMAS, MARY ELIZABETH</b>		2. DATE AND HOUR OF DEATH <b>10-10-66 1 335 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		C. CITY OR TOWN (If outside city limits, write FULL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2228 BUSKIN AVE.</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED</b>	8. DATE OF BIRTH <b>6-7-07</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BEAUTICIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>59</b>
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walker Twyman</b>		14. MOTHER'S MAIDEN NAME <b>Rosa</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-8194</b>	
17. INFORMANT		ADDRESS <b>RECORDS-BCH-4940 Eastern Avenue-21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>(A) Carcinoma of Colon &amp; SPINE metastasis.</b> <b>(B) DUE TO</b> <b>(C)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 AD MITTS</b> <b>1-6 YRS</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>3-4-66</b> 19 <b>66</b> to <b>10-10</b> 19 <b>66</b> , that <del>the</del> (we) last saw the deceased alive on <b>10-10</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Richard Maffezzoli</b>		23B. DATE SIGNED <b>10-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAFFEZZOLI, RICHARD</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/14/66</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Wm. C. March</b>		ADDRESS <b>928 E. North Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 10234</u>	
BIRTH NO. <u>66 10234</u>		M.E. CASE NO. <u>62-20616</u>					
1. NAME OF DECEASED (Type or Print) <u>TOYA GRIFFIN</u>				2. DATE AND HOUR OF DEATH <u>10-10-66</u> <u>5:25P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>25-32</u> D. STREET ADDRESS (If rural, give location) <u>609 CHERRY CREST RD. 21225</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>CHILD</u>	8. DATE OF BIRTH <u>8-3-62</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CARROLL GRIFFIN</u>				14. MOTHER'S MAIDEN NAME <u>JOAN CLEMENT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Carroll Griffin Jr. 609 Cherry Crest Rd.</u>			
18. <u>292.61</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Sickle cell crisis</u> DUE TO (B) <u>Sickle cell disease</u> DUE TO (C) <u>Pulm edema + infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>from birth</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Infection of undetermined etiol</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20A. AUTOPSY? (Yes or No) To <u>YES NONE</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NONE</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 10 5:30 AM 1966</u> to <u>Oct 10 5:25 PM 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 10 5:25 PM 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jerrold J. Yecies</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>Oct, 10, 1966</u>			
23C. PHYSICIAN'S NAME (Type) <u>JERROLD J. YECIES</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSP.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/13/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter-3035 W. North Ave.</u>			

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TERO D. YERIES

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✓ OCT 12 1962

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 10235					CERTIFICATE OF DEATH					Registered No. 66 10235									
1. NAME OF DECEASED (Type or Print) <i>John Cordray McGee</i>					2. DATE AND HOUR OF DEATH <i>7 Oct 66</i> <i>12<sup>10</sup></i> P.M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>38</i>					A. STATE <i>Delaware</i>					B. COUNTY									
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Dagsboro</i>					V-07									
					D. STREET ADDRESS (If rural, give location)														
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>27 Feb 1903</i>		9. AGE (In years last birthday) <i>63</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Banker</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Farmer's Bank of Dagsboro</i>					11. BIRTHPLACE (State or foreign country) <i>Del.</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>John McGee</i>					14. MOTHER'S MAIDEN NAME <i>Unkn</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unkn</i>					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Wife</i>					ADDRESS				
18. <i>381X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Intracerebral hemorrhage</i> and <i>28 Sept 66</i> DUE TO (B) <i>Subarachnoid hemorrhage</i> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <i>" " "</i>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonia</i>																			
19A. DATE OF OPERATION <i>9/28/66</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intracerebral hemorrhage</i>					20A. AUTOPSY? (Yes or No) <i>No</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>-</i>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>					21C. WHERE DID INJURY OCCUR? <i>-</i>					(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) <i>-</i>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? <i>-</i>									
22. I certify that (I) (this hospital) attended the deceased from <i>28 Sept 1966</i> to <i>7 Oct 1966</i> , that (I) (we) last saw the deceased alive on <i>7 Oct 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>Robert S. Holt</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>7 Oct 66</i>									
23C. PHYSICIAN'S NAME (Type) <i>Robert S. Holt</i>					M.D. <i>University Hospital</i>					23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>					24B. DATE <i>10-10-66</i>					24C. NAME of CEMETERY or CREMATORY <i>DAGSBORO Memorial Cem.</i>					24D. LOCATION (City, town, or county) (State) <i>DAGSBORO, DELA.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 11 1966</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR <i>John Dagsboro Nelson, Frankford, Del.</i>					ADDRESS				

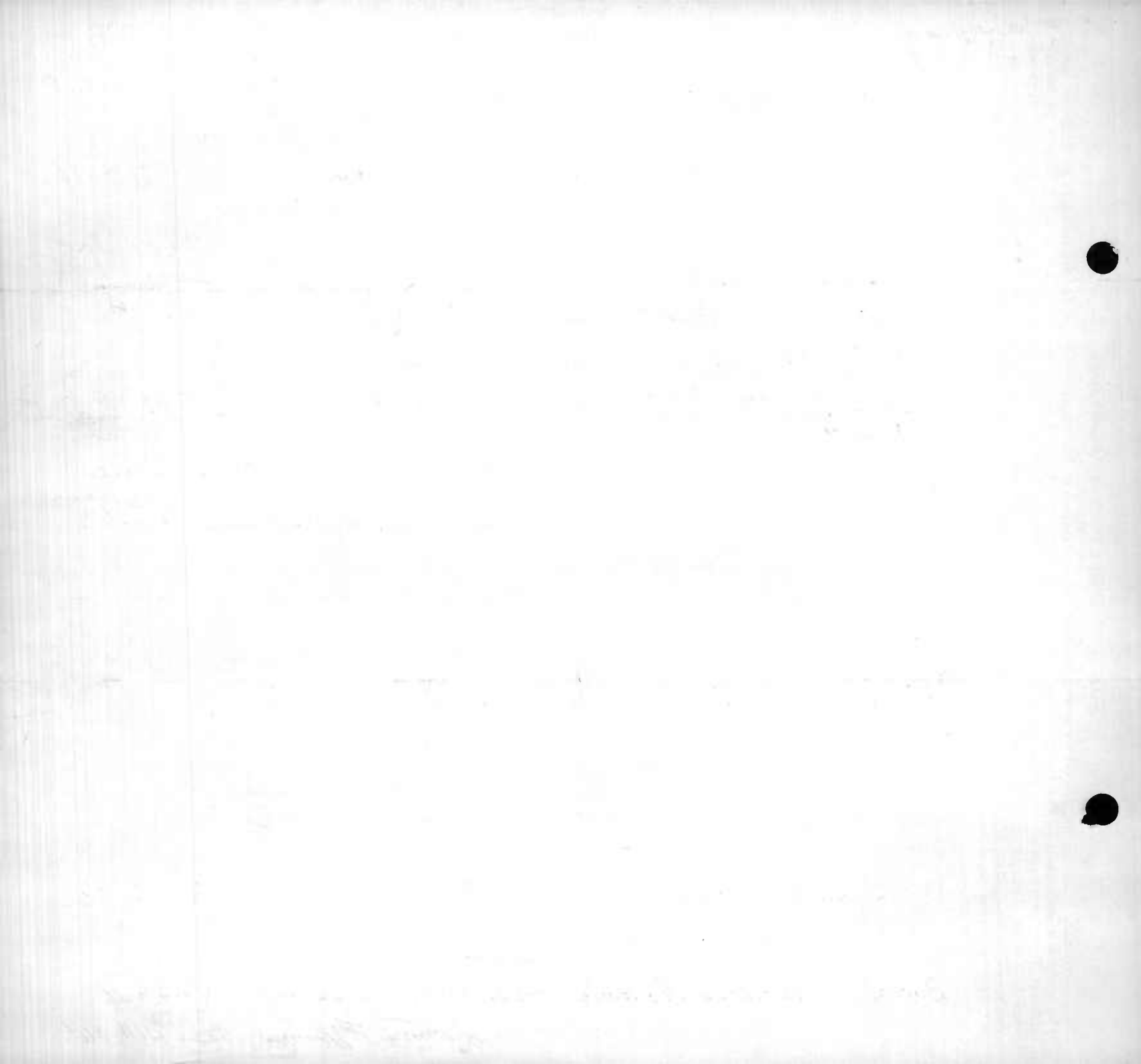


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

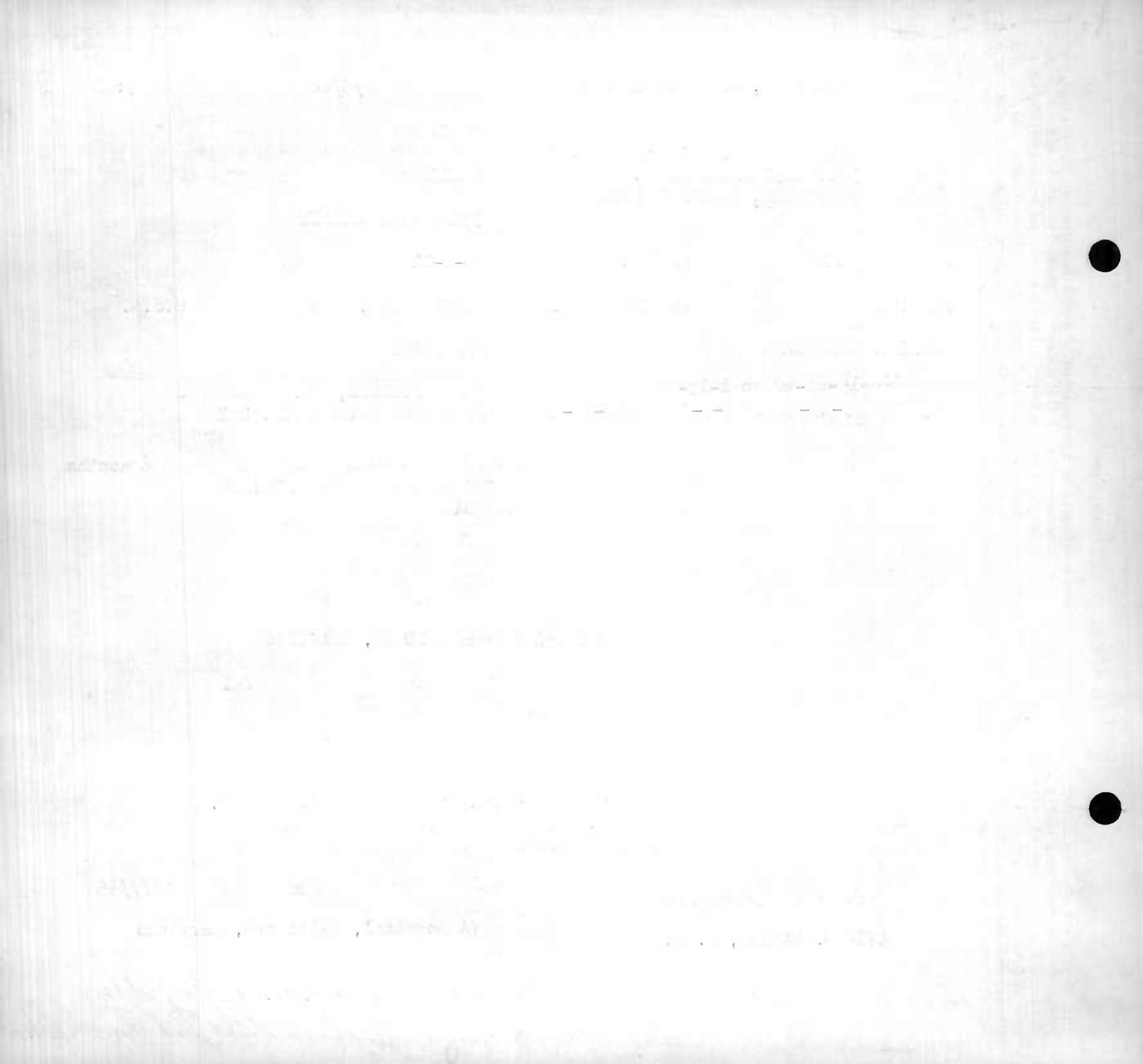
BALTIMORE CITY HEALTH DEPARTMENT				X	
BIRTH NO.		66 10236		Registered No. 66 10236	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Victor Buhr</i>			2. DATE AND HOUR OF DEATH <i>6 Oct 66 4 4:27 P M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i> <i>33</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Wicomico Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Salisbury</i> D. STREET ADDRESS (If rural, give location) <i>72-12</i> <i>708 S. Park Drive</i>		
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>June 21, 1898</i>	9. AGE (In years lost birthday) <i>68</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Architectural</i>		11. BIRTHPLACE (State or foreign country) <i>New York City</i>	
13. FATHER'S NAME <i>Victor William Buhr</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War II 1941-1942</i>			16. SOCIAL SECURITY NO. <i>111-07-21387</i>		17. INFORMANT <i>Mrs. Ellen Buhr</i>
18. <i>154 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Abdominal carcinomatosis</i> DUE TO (B) <i>Carcinoma of rectum</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> <i>3 years</i> <i>Nov 63</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i>					
19A. DATE OF OPERATION <i>Nov. 63</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of rectum</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on <i>6 Oct</i> 19 <i>66</i> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <i>William E. Grose</i> WILLIAM E. GROSE				23B. DATE SIGNED <i>6 Oct 66</i>	
23C. PHYSICIAN'S NAME (Type) M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> WILLIAM E. GROSE				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-10-66</i>		24C. NAME OF CEMETERY <i>Makemie Presbyterian</i>	
24D. LOCATION <i>Snow Hill, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 11 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>John E. Fairbank, Snow Hill, Md.</i>			





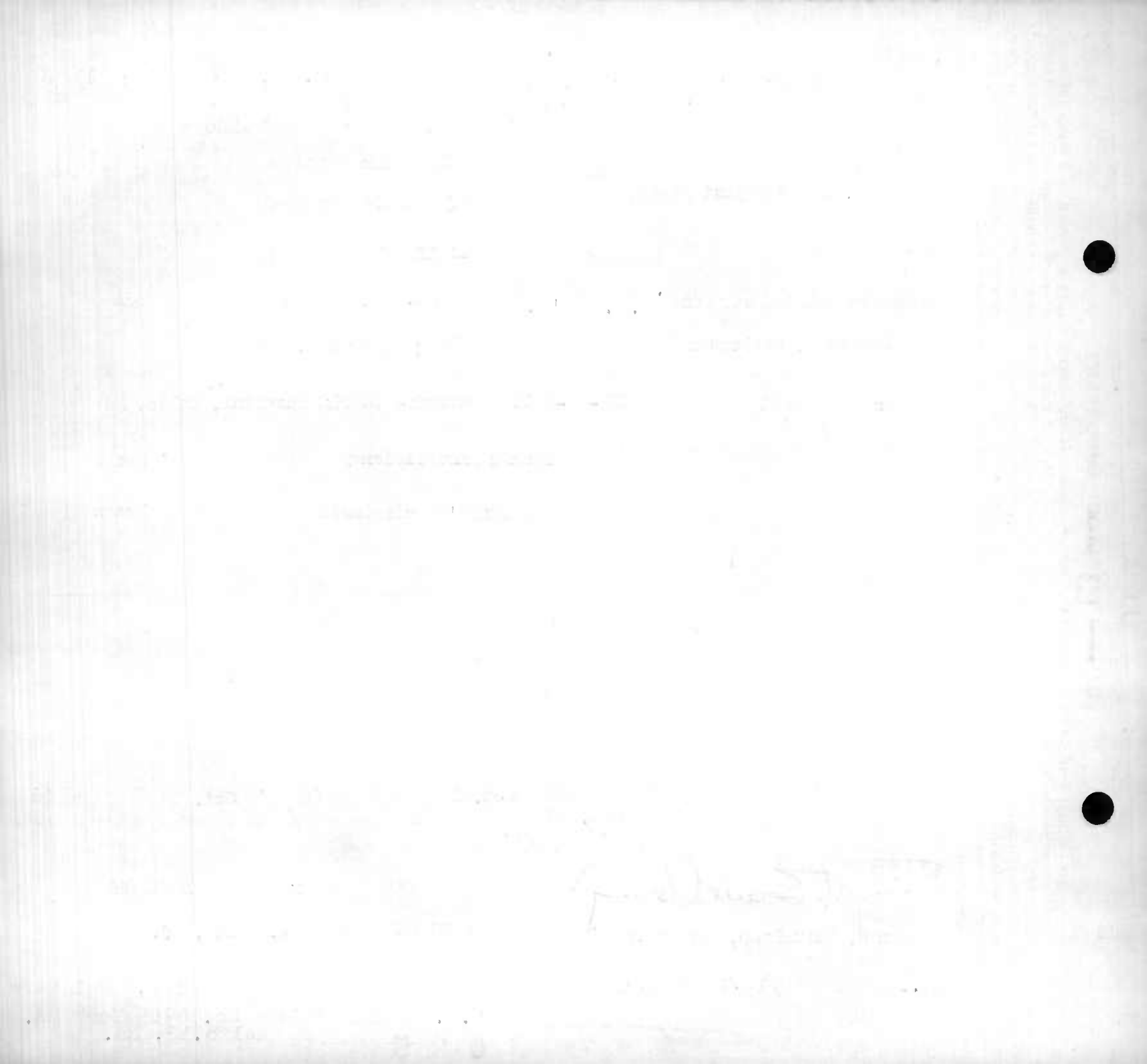
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10238</span>	
BIRTH NO. <span style="float: right;">66 10238</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Gilbert Harrington Mathewson</b>				2. DATE AND HOUR OF DEATH <b>Oct. 10, 1966</b> <span style="float: right;">2: 20 P M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>Wyman Pk. Drive &amp; 31st Street</b>				A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> <span style="float: right;">53-00</span>				D. STREET ADDRESS (If rural, give location) <b>745 Weatherbee Road</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDQWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/20/07</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Property Administrator U.S. Gov't.</b>			11. BIRTHPLACE (State or foreign country) <b>XXX New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles G. Mathewson</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Harrington</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>			16. SOCIAL SECURITY NO. <b>221-01-2028</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md</b>
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Hepatic insufficiency</b>				<b>Weeks</b>	
(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES <b>Laennec's cirrhosis</b>				<b>Years</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1</b> <b>1966</b> to <b>Oct. 10</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>Oct. 10</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jon M. Beauchamp</i>				23B. DATE SIGNED <b>10/11/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jon M. Beauchamp, Surgeon (R)</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>10/13/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Lower Brandywine</b>	
24D. LOCATION <b>New Castle County, Delaware</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 11 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto, 12, Md.</b>			



66 10239

BALTIMORE CITY HEALTH DEPARTMENT

66 10239

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH M.

ELLISON (Johnson)

2. DATE AND HOUR PRONOUNCED DEAD

September 7, 1966

10:30 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

709 W. Lexington Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

709 W. Lexington Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Phila. Pa.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lavila Pino

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-22-1737

17. INFORMANT

ADDRESS

Mrs. Mary Long 1110 N. Stricker St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Carcinoma of uterine cervix with  
Metastatic Carcinoma metastases

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/12/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn C.

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. C. Mord, 928 E. North Ave.

ADDRESS

Letter from M.E.'s office

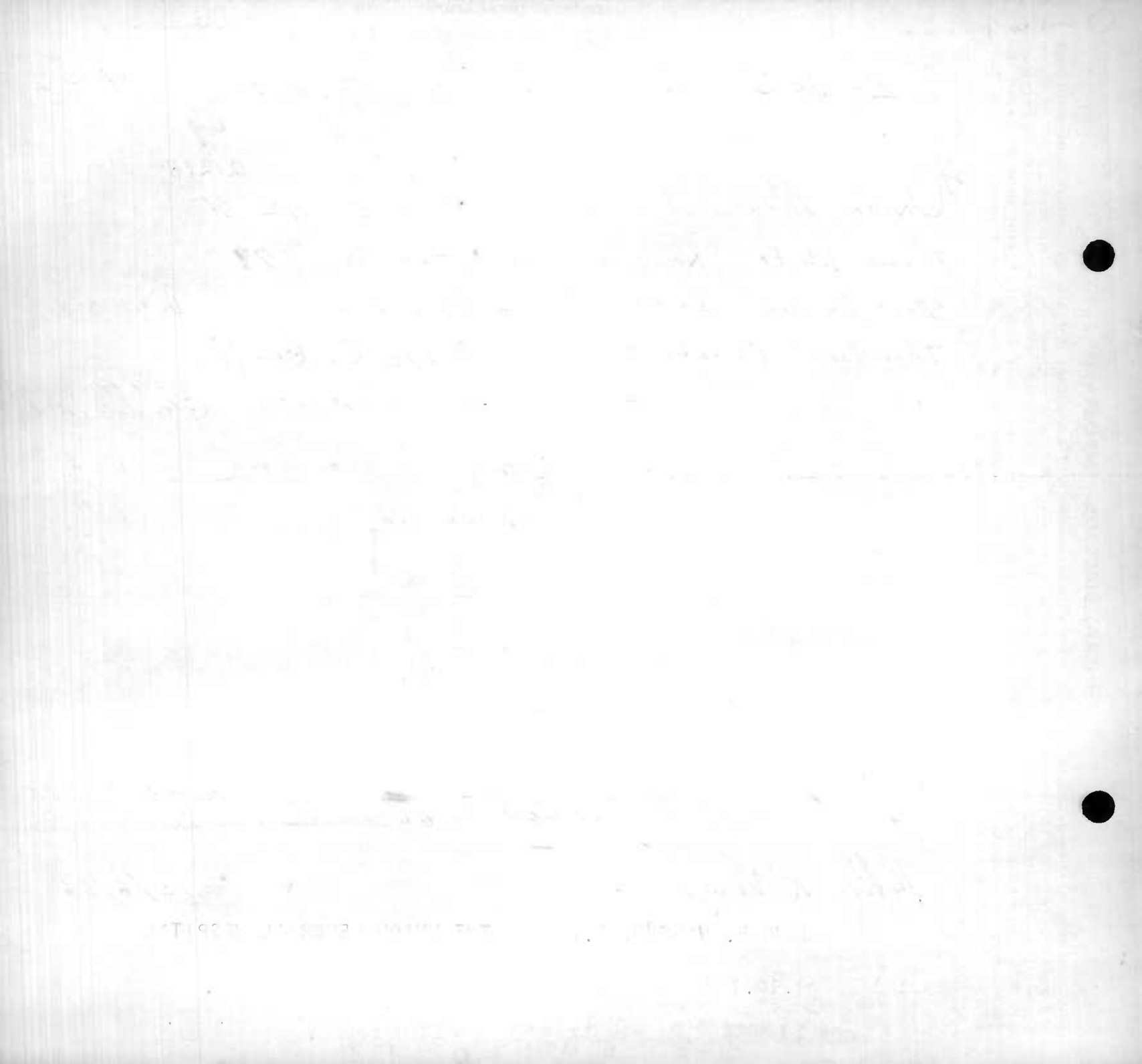
10-14-66  
M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10240		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10240	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNIE CATHERINE OVERBECK		2. DATE AND HOUR OF DEATH 10/6/66 4:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		A. STATE Maryland		B. COUNTY 9-06	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		21218	
		D. STREET ADDRESS (If rural, give location) 1900 E. 31st St.			
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 12-14-88	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK BROKER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK BROKER		10B. KIND OF BUSINESS OR INDUSTRY Investment Banking		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Theodore Overbeck		14. MOTHER'S MAIDEN NAME Annie C. Graft	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-05-2729		17. INFORMANT Mrs. James G. Moore, Sr.	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) Pneumonia DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 10-1-66 to 10-6-66, that (X) (we) last saw the deceased alive on 10-6-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Vaughn Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/6/66	
23C. PHYSICIAN'S NAME (Type) JOHN R. VAUGHN, JR.,		M.D. THE UNION MEMORIAL HOSPITAL		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 10. 1966		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) Baltimore Md.		24E. STATE (State) Baltimore Md.		24F. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR J. B. E. Fairley		25C. ADDRESS Baltimore Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10241				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10241	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HOLMES, CLARA May</b>				2. DATE AND HOUR OF DEATH <b>10-11-66</b>		<b>6:15 A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b> <b>44</b>				A. STATE <b>MARYLAND</b> B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>507 ROSSITER AVENUE</b>			
5. SEX <b>F</b>	6. RACE <b>CAU</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>01-22-'77</b>	9. AGE (In years last birthday) <b>89</b>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM GREEN</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE HILL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ADMISSION RECORD</b>		ADDRESS	
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b>				CAUSE OF DEATH (A) <b>CONGESTIVE HEART FAILURE</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>16 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>ATHEROSCLEROTIC HEART DISEASE</b> DUE TO			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NONE</b>							
19A. DATE OF OPERATION <b>0 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>			
21D. TIME OF INJURY (APPROX.) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>NONE</b>		21F. HOW DID INJURY OCCUR? <b>NONE</b>			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3 Oct</b> 19 <b>66</b> to <b>11 Oct</b> 19 <b>66</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>10 Oct</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>Was</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Jeff Parker</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11 Oct '66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JEFF PARKER</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL 33RD + CALVERT STS; BALT, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Govans Presbyterian</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10242	
BIRTH NO. 66 10242		M.E. CASE NO.		1. NAME OF DECEASED MICELI VINCENT A	
2. DATE AND HOUR OF DEATH 10/10/66 5 p M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland		5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			
8. DATE OF BIRTH 1-1-13 9. AGE (In years last birthday) 53 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Helper 10B. KIND OF BUSINESS OR INDUSTRY Laborer Baltimore City			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Anthony Miceli		14. MOTHER'S MAIDEN NAME Unknown (Mary)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-0476		17. INFORMANT ADDRESS Mrs. Leota M. Miceli 11 N. Port St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO pulmonary edema (B) DUE TO uremia (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/10/66 to 10/10/66, that (I) (we) last saw the deceased alive on 10/10/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodelio M. Lim M.D.		23B. DATE SIGNED 10-10-66		23C. PHYSICIAN'S NAME (Type) Rodelio M. Lim M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/14/66		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 11 1966		25B. NAME OF REGISTRAR John A. Mpran, Inc.	
25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St.					

10-10-50  
Bureau of the  
Geological Survey  
Clark House - 10-10-50

R-100

66 10243

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10243

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANDREW ROBB

2. DATE AND HOUR PRONOUNCED DEAD

October 9, 1966

3:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1701 O'Dell Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

5/3/1894

9. AGE (in years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Custodian

10B. KIND OF BUSINESS OR INDUSTRY

Elementary School

11. BIRTHPLACE (State or foreign country)

Glasgow, Scotland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Robb

14. MOTHER'S MAIDEN NAME

Annie Gordon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
214-01-4800  
yes

17. INFORMANT

ADDRESS

Angus K. Robb, Great Mills, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/13/66

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 11 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore

ADDRESS

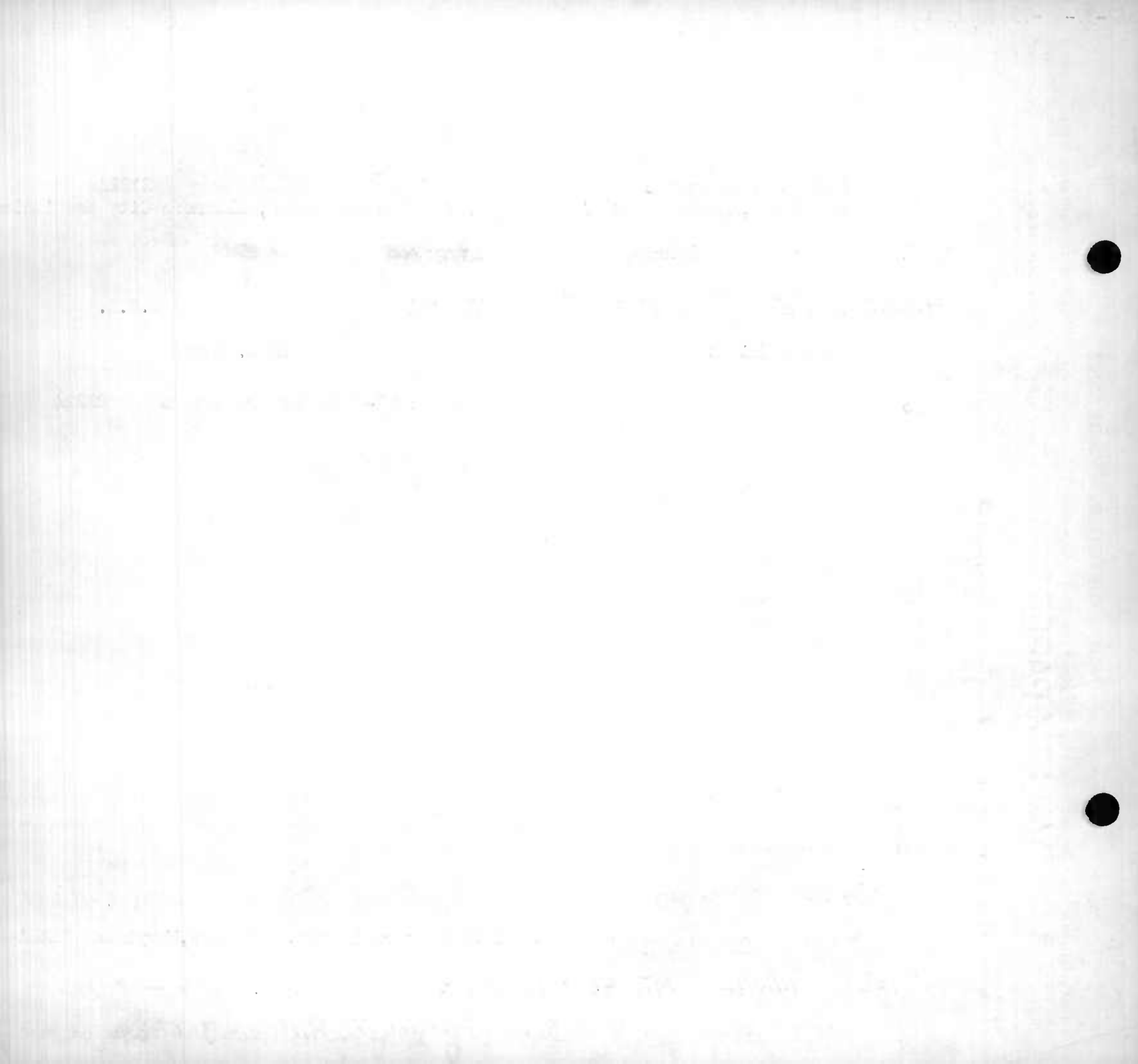
St.



WALLEN DOWNS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

- 520 BIRTH NO.		66 10244		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10244	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Thomas, Myrtle</b>			
2. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH <b>10-10-66 1 10 <sup>20</sup> AM.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				A. STATE <b>Maryland</b> B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 26-12 21224</b>			
D. STREET ADDRESS (If rural, give location)				<b>4940 Eastern Avenue, Baltimore City Hospitals</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>11/21/99</b>	9. AGE (In years last birth) <b>67</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Height</b>				14. MOTHER'S MAIDEN NAME <b>Eliz. Mason</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 12 19 65</b> to <b>Oct. 10 19 66</b> , that (I) (we) last saw the deceased alive on <b>Oct. 10 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ross Krueger</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct. 10, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ross Krueger</b>				23D. ADDRESS <b>M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/15/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. AUBURN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO, CITY - MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Margaretta B. Brown 3106 Calhoun Ave</b>			



B-220

66 10245

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10245

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Leonard Charles Busick

2. DATE AND HOUR PRONOUNCED DEAD

10/10/66 7:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21

D. STREET ADDRESS (If rural, give location)

902 Holgate Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 22, 1917

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Driver

10B. KIND OF BUSINESS OR INDUSTRY

Messenger Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Busick

14. MOTHER'S MAIDEN NAME

Eleanor Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL  
SECURITY NO.

218 01 9969

17. INFORMANT

Margaret Busick

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/11/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/14/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 12 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

James E. Bruzdinski 1407 Eastern Ave.

WALTON POLICE

RECEIVED

Driver  
Insurance Co.  
Insured  
April 22, 1917  
Baltimore, Md.  
Charles H. Jones  
218 E. 9th St.  
Baltimore, Md.

10/10/10  
Baltimore National Century Building

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 10246				
BIRTH NO. 66 10246					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) TERESA MRAZECK					2. DATE AND HOUR OF DEATH 10-10-66 12:15 PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
38		University Hosp.			1620 Sunshine St.		Glen Burnie Md		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
BALTIMORE					52-00				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
F	C	child		6-28-61	5 yr				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
				md.		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Stanley Mrazek					Mary Banocky				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
			None		Stanley A. Mrazek (Father)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO Hemorrhage			3 mos	
ANTECEDENT CAUSES					(B) DUE TO Aplastic Anemia				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					none				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 10-1-1966 to 10-11-1966, that (I) (we) last saw the deceased alive on 10-20-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
Misbah Khan								10-11-66	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Misbah Khan					Peel Dept University Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		10/14/66		Holly Hill Cemetery		Baltimore County			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS		
OCT 12 1966		Robert E. Taylor		Raymond C. Eink			Glen Burnie, Md.		

31



K-45

66 10247

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 10247

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELEANOR J. KLINEFELTER

2. DATE AND HOUR PRONOUNCED DEAD

October 7, 1966 9:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Reisterstown

D. STREET ADDRESS (If rural, give location)

Hanover Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 2, 1923

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Hospital Laundry Employee

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Butler, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Luther W. Klinefelter

14. MOTHER'S MAIDEN NAME

Cora Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

179-20-9681

17. INFORMANT

Mr. William M. Klinefelter

ADDRESS

Reisterstown, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Severe Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

St. Rt. 150, 1/4 mile W. of Wilson Point

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 7 '66 8:30

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Charles S. Springate

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/11/66

23C. NAME of CEMETERY or CREMATORY

Black Rock Cemetery

23D. LOCATION

(City, town, or county)

Butler, Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 12 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

J. F. Eline &amp; Sons Reisterstown, Md.

ADDRESS

N 8672660030260

WALTER EUGENE

G-155

66 10248

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66-10248

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE W. COFFMAN

2. DATE AND HOUR PRONOUNCED DEAD

October 10, 1966 9:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Balto. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

53-00  
5713 Edmondson Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

7/21/89

9. AGE (In years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

MERCHANT

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES I. COFFMAN

14. MOTHER'S MAIDEN NAME

VIRGINIA HAMMON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS

MRS ROBERT H. ROBERTSON JR

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)53-00  
Intersection of Coldridge Rd. & Rt. 4021D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 22 '66 3:40 P

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver Auto-auto accident

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

ENTOMBMENT 10/12/66

LORRAINE

BALTO. CO. MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

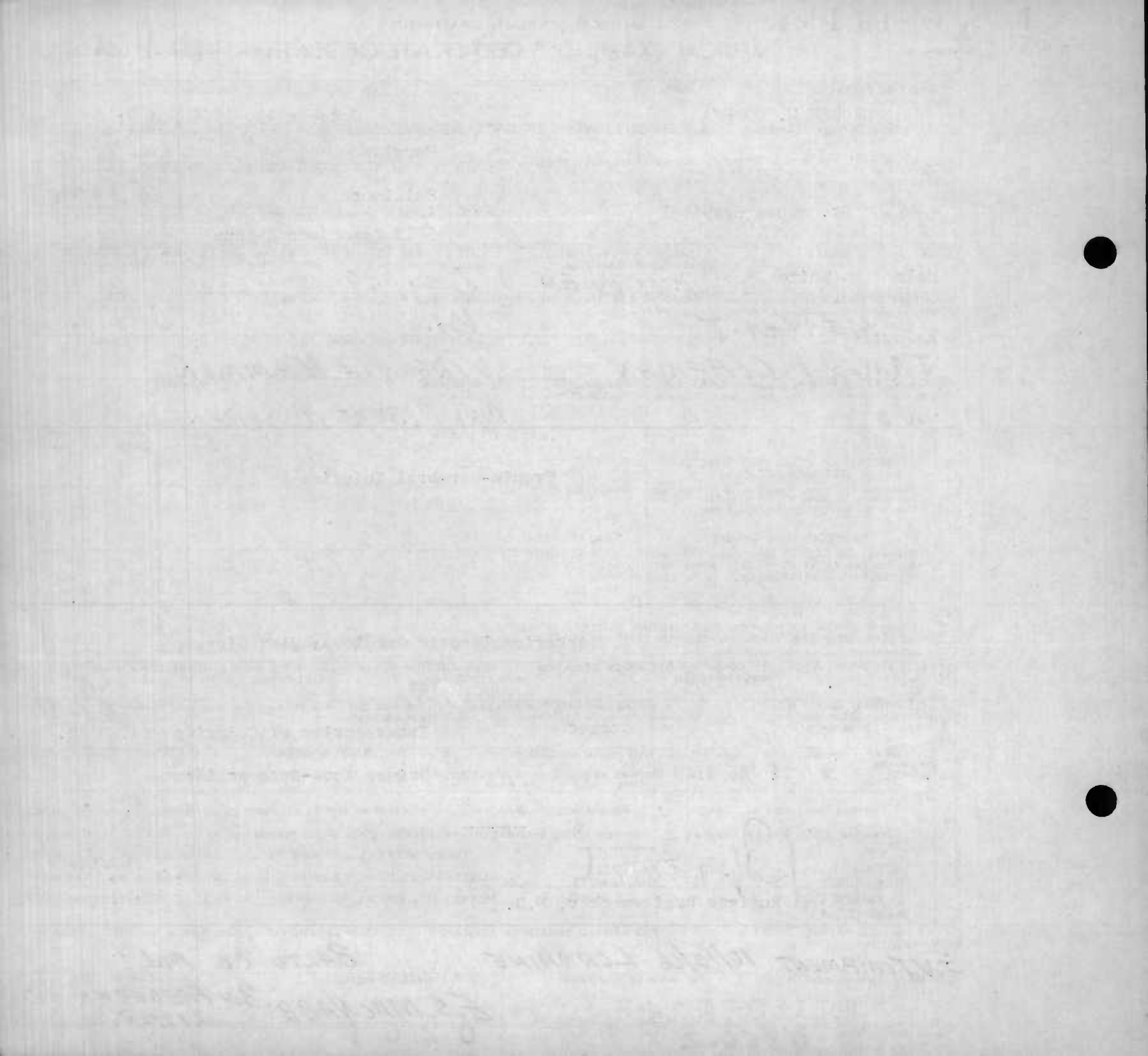
ADDRESS

OCT 12 1966

Rudiger E. Breiteneker

F.S. MACNABB

301 FREDERICK RD  
21228



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10249		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10249	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILDRED WILSON		2. DATE AND HOUR OF DEATH 10/9-66 750/9 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE WEST VIRGINIA B. COUNTY KINGWOOD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-45	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 115 MAC DONALD ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-18-14	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME FRED CUPP		14. MOTHER'S MAIDEN NAME ANNA GOVEDICK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Kiger-Williams - Personal Home Address Kingwood W Va	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 200.01 RETICULUM CEREBRUM of brain		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/9/22 1966 to 10/9 1966, that (I) (we) last saw the deceased alive on 10/9 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		23A. SIGNATURE Peter F. Rosen		23B. DATE SIGNED 10/9/66	
23C. PHYSICIAN'S NAME (Type) PETER F. ROSEN		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION REMOVAL (Specify) Removal 10/10/66		24B. DATE 10/10/66		24C. NAME OF CEMETERY or CREMATORY Maplewood	
24D. LOCATION (City, town, or county) (State) W. Va		25A. DATE REC'D BY HEALTH DEPT. OCT 12 1966		25B. NAME OF REGISTRAR E. E. Fadden	
25C. FUNERAL DIRECTOR Philip Herring Sons		25D. ADDRESS 2024 Williams St			

100-100

100-100

100-100



A-352

66 10250

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 10250

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

HERCHEL

L.

ADAMS

2. DATE AND HOUR PRONOUNCED DEAD

October 9, 1966

3:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

506 S. Hanover Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

22-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

506 S. Hanover Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

May 1899

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Transportation

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

William T. Adams

14. MOTHER'S MAIDEN NAME

Margaret M. Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-16-7044

17. INFORMANT

ADDRESS Pasadena, Md.

Mrs. Margaret Henderson 3720 Mountain Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive  
DUE TO Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Cancer of Lung (By History)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct. 12, 1966 Magothy Methodist

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Jacobsville, A. A. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 12 1966

George J. Gonce 4001 Ritchie Hwy. Balto. Md.

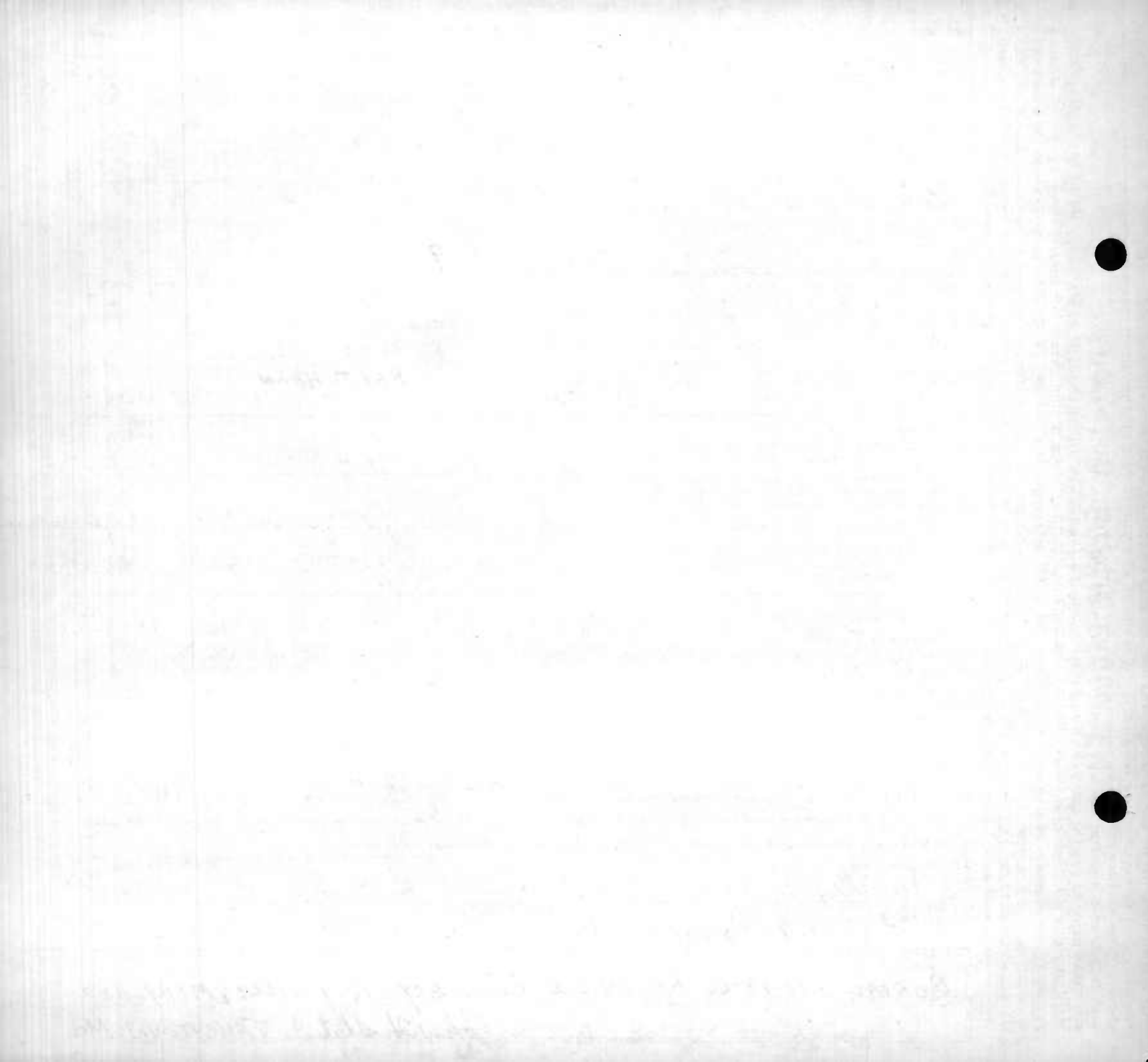


VALLEY POLICE  
RAB. 1110

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

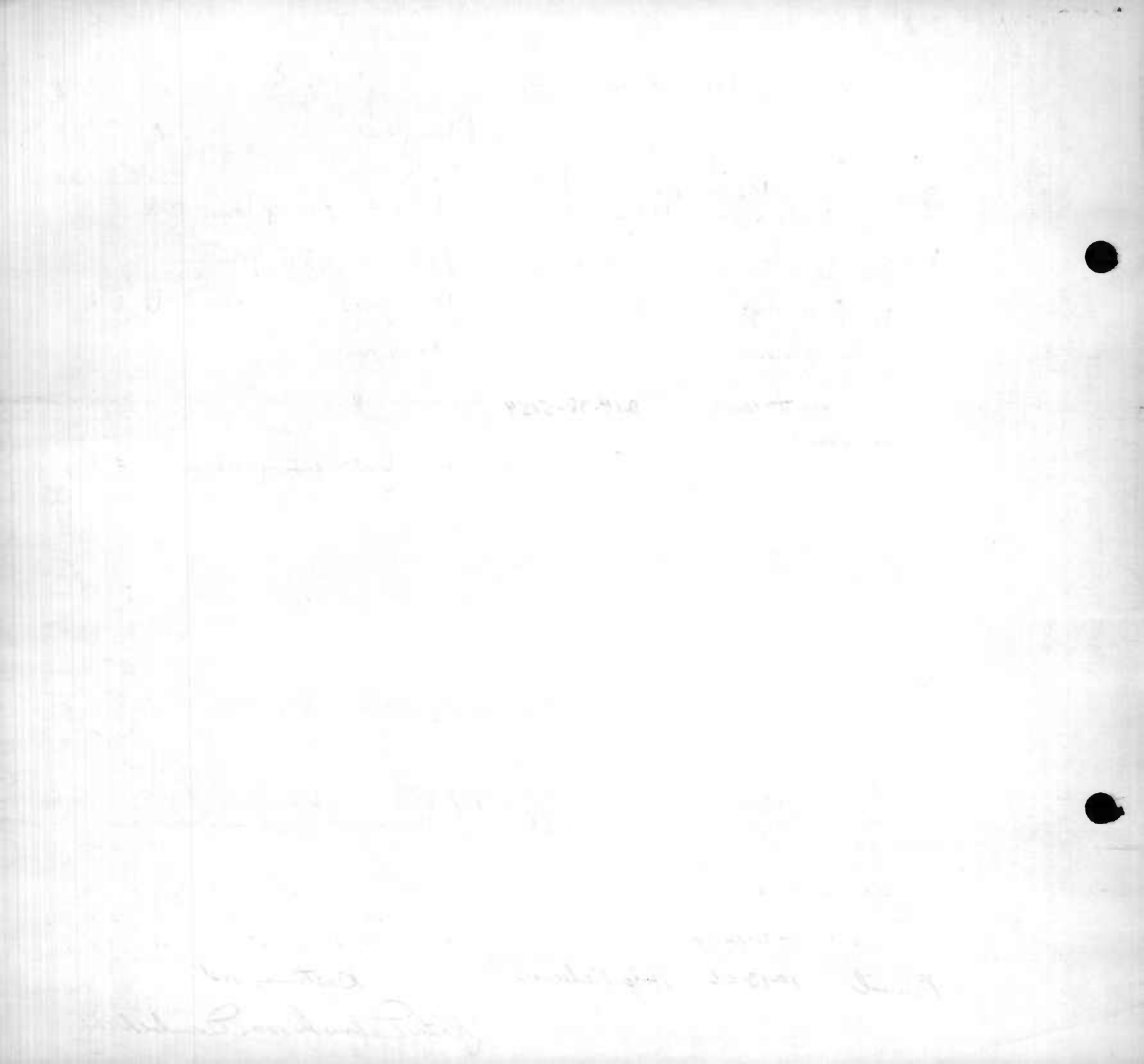
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10251	
BIRTH NO. 66 10251		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Hahn Georgia Pearl</b>		2. DATE AND HOUR OF DEATH <b>OCT 10 '66 10 15 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 UNIVERSITY Hosp. BALTIMORE</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>Anne Arundel Co.</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>TANEYTOWN 56-20</b>			
		D. STREET ADDRESS (If rural, give location) <b>N/A</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-9-18</b>	9. AGE (in years, last birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VA.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>MITCHELL LIVESAY</b>		14. MOTHER'S MAIDEN NAME <b>ELVA GLASS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>RAY T. HAHN HUSBAND</b> ADDRESS <b>S/A</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Cardiac arrest</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) <b>Infection of myocardium</b> DUE TO		<b>Unknown</b>	
		(C) <b>Coronary atherosclerosis</b> DUE TO		<b>Unknown</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Enterocutaneous fistula &amp; malabsorption</b>					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 10 8:15am 19 66</b> to <b>OCT 10 10:15am 19 66</b> , that (I) (we) last saw the deceased alive on <b>OCT 10, 10:15am 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Timothy Kenney Gray</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>10-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>TIMOTHY KENNEY GRAY</b> M.D.		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10-13-66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>KEYSVILLE CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>KEYSVILLE, MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1966</b>	25B. NAME OF REGISTRAR <b>A. G. E. Fawcett</b>	25C. FUNERAL DIRECTOR ADDRESS <b>John H. Skiles TANEYTOWN, Md.</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

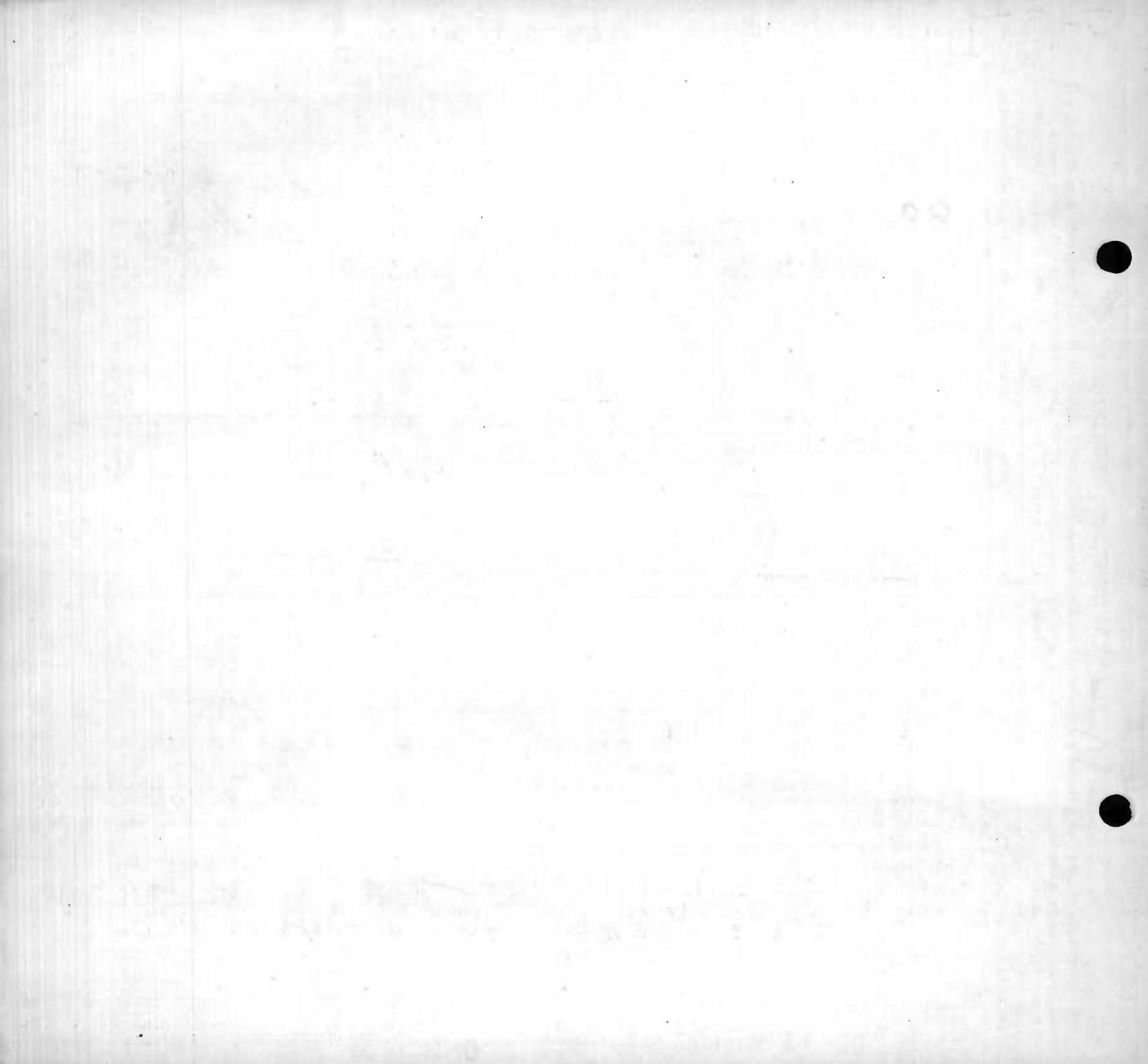
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10252</b>	
BIRTH NO. <b>66 10252</b>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GOEB, Mr GEORGE SR.</b>		2. DATE AND HOUR OF DEATH <b>10/8/66 6 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home &amp; Hospital</b> <b>100 N. Broadway</b> <b>Baltimore, Md 21231</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 53-00</b>		D. STREET ADDRESS (If rural, give location) <b>6823 Youngstown ave</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widower</b>	8. DATE OF BIRTH <b>5/27/88</b>	9. AGE (In years lost birthday) <b>78 yrs</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Capt. Fire Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Fire Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MARDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>214-38-5154</b>		17. INFORMANT ADDRESS	
18. <b>527.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Acute pulmonary edema 2 days</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/8</b> 19 <b>66</b> to <b>10/8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mariano</b>				23B. DATE SIGNED <b>10-8-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>I. C. MARIANO</b>		23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL</b> <b>BALTIMORE, MD. 31</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-13-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Walter Dabrowski 1005 Dundick ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10253</u>	
BIRTH NO. <u>66 10253</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>DAYTON B. SKADDEN</u>		2. DATE AND HOUR OF DEATH <u>OCTOBER 9, 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>406 Old Orchard Road</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			D. STREET ADDRESS (If rural, give location) <u>406 Old Orchard Rd.</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>March 31, 1900</u>	9. AGE (In years lost birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturing Chemist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chemical Man;</u>		11. BIRTHPLACE (State or foreign country) <u>Cleveland, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Harrison B. Skadden</u>		
14. MOTHER'S MAIDEN NAME <u>Florence Spesshardt</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW I</u>		
16. SOCIAL SECURITY NO. <u>131-10-3615</u>			17. INFORMANT <u>Mrs Lillian J. Skadden</u>		
18. <u>443 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CHF</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>HA S-I-D</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/12</u> 19 <u>62</u> to <u>10/9</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>I. S. ZINBERG</u>			23B. DATE SIGNED <u>10/10/66</u>		
23C. PHYSICIAN'S NAME (Type) <u>I. S. ZINBERG</u>			23D. ADDRESS <u>4000 W. Northern Pk way</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Oct 12, 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. National Cemt. Baltimore, Maryland</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>STERLING FUNERAL ESTATE</u>			
25D. ADDRESS <u>Catoonsville 28, Md.</u>		25E. ADDRESS <u>236 Edm. Av.</u>			

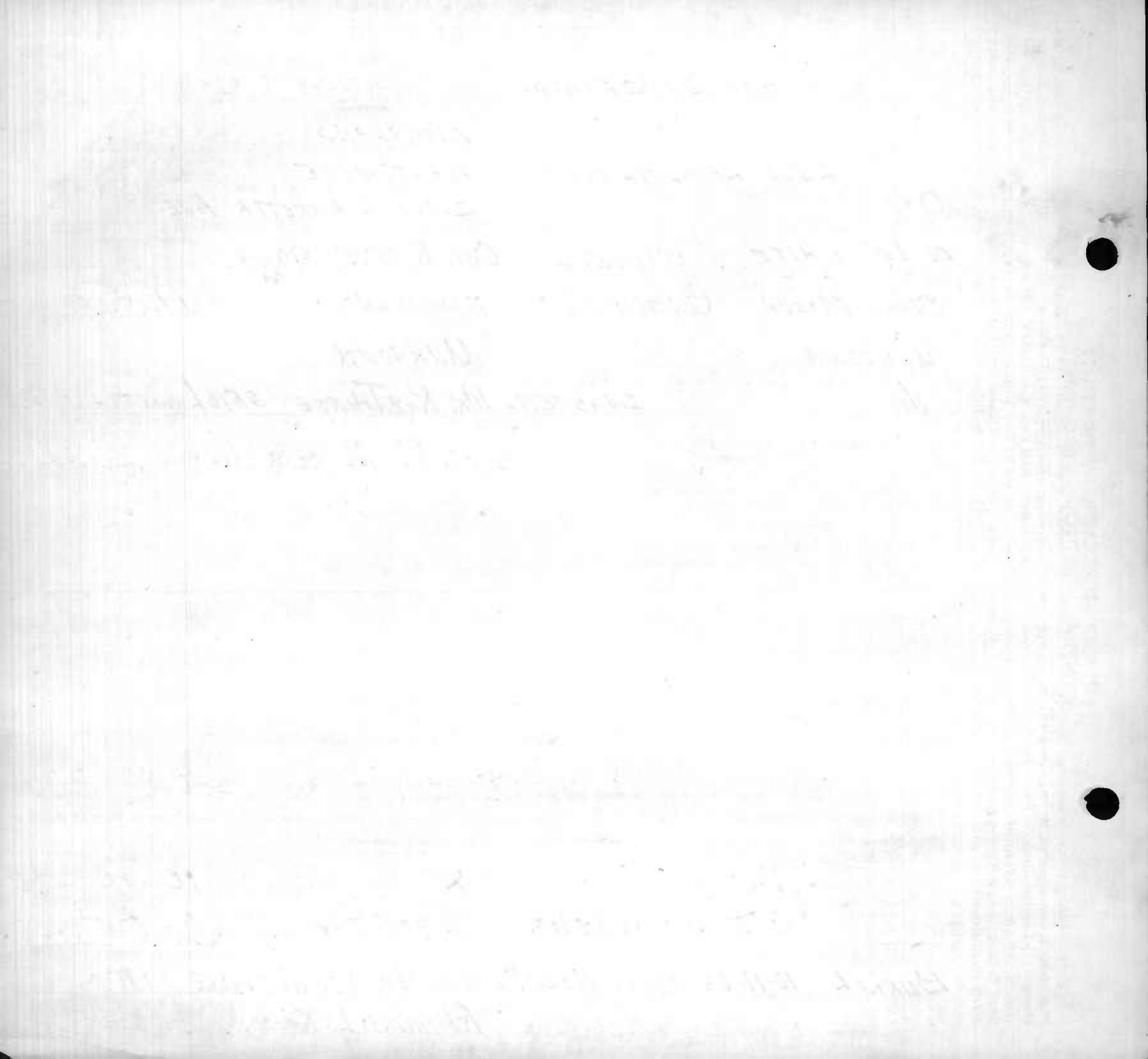




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10254	
BIRTH NO. 66 10254		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN S. GRIMM		2. DATE AND HOUR OF DEATH OCTOBER 8, 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE MARYLAND B. COUNTY 20-02	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2510 LAURETTA AVE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 2510 LAURETTA AVE.	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH OCT. 18 1875	9. AGE (In years last birthday) 90 YRS.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STONE MASON		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-3569A		17. INFORMANT MR. RAY THORPE ADDRESS 2510 LAURETTA AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Infarct Myocardial (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1 19 50 to Oct 8 19 66, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE CJ Mendelis M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-10-66	
23C. PHYSICIAN'S NAME (Type) CJ Mendelis M.D.		23D. ADDRESS 2308 E. Edmondson Ave Baltimore 23 m			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-11-66		24C. NAME OF CEMETERY or CREMATORY NORRISVILLE METHODIST CEM.	
24D. LOCATION NORRISVILLE M.D.		25A. DATE REC'D BY HEALTH DEPT. OCT 12 1966		25B. NAME OF REGISTRAR RAYMOND L. KACZOROWSKI	
25C. FUNERAL DIRECTOR ADDRESS 2525 FLEETS		VS 150-REV. 1			



1  
B-550

66 10255

BALTIMORE CITY HEALTH DEPARTMENT

66 10255

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CARL ELMO BOWMAN

2. DATE AND HOUR PRONOUNCED DEAD

OCTOBER  
September 9, 1966

11:20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1807 E. Baltimore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1807 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

6-21-1919

9. AGE (In years  
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

TENNESSEE

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT BOWMAN

14. MOTHER'S MAIDEN NAME

BETTY GREEN BOWMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MR. SAM BOWMAN 1635 E. BALTIMORE

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty Metamorphosis of Liver, Severe  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-14-1966

23C. NAME of CEMETERY or CREMATORY

MCKINLEY MEM. CHURCH CEM.

23D. LOCATION

(City, town, or county)

(State)

JOHNSON CITY TENNESSEE

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

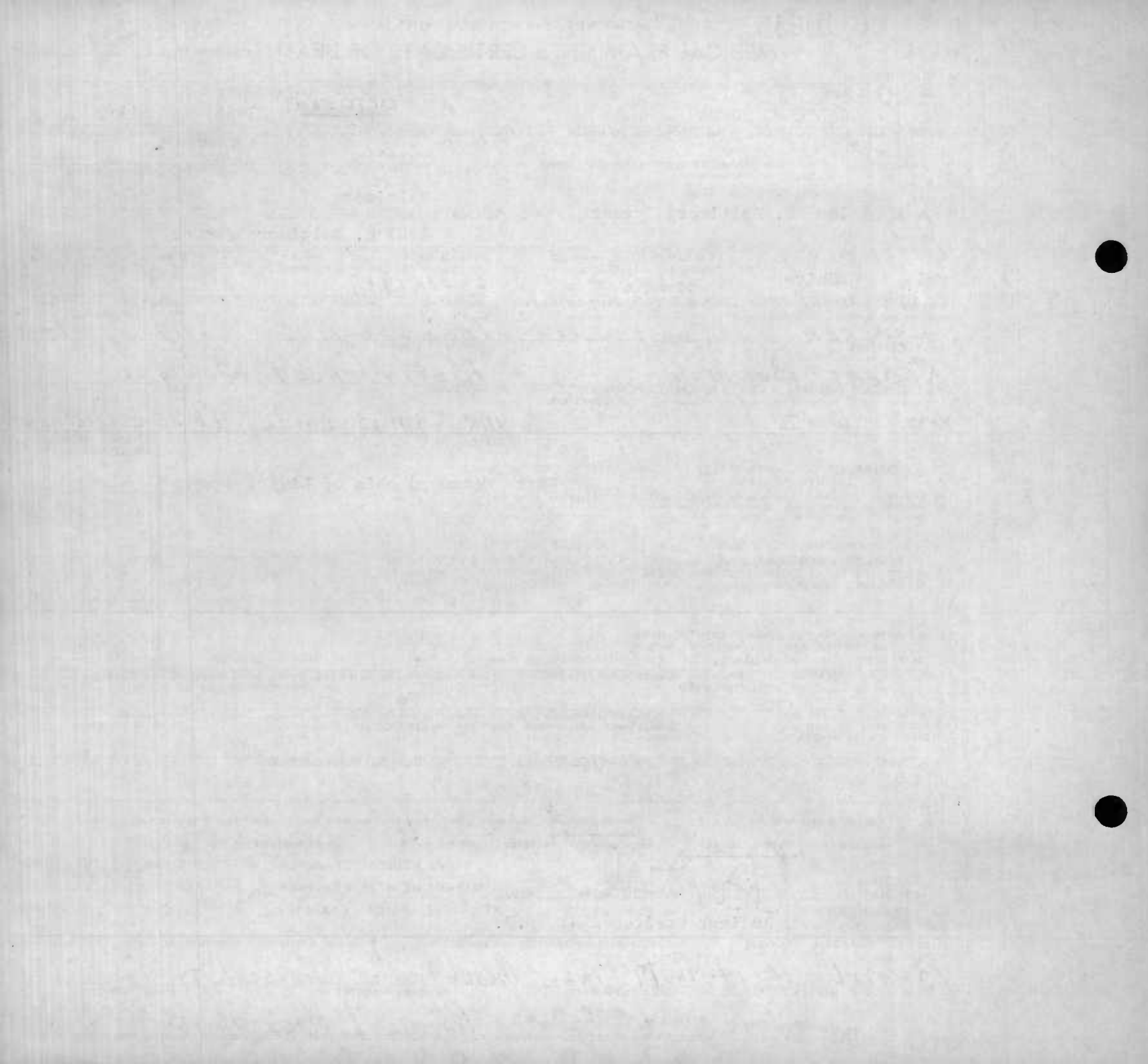
ADDRESS

OCT 12 1966

A. D. &amp; E. F. F. F.

RAYMOND L. KACZOROWSKI

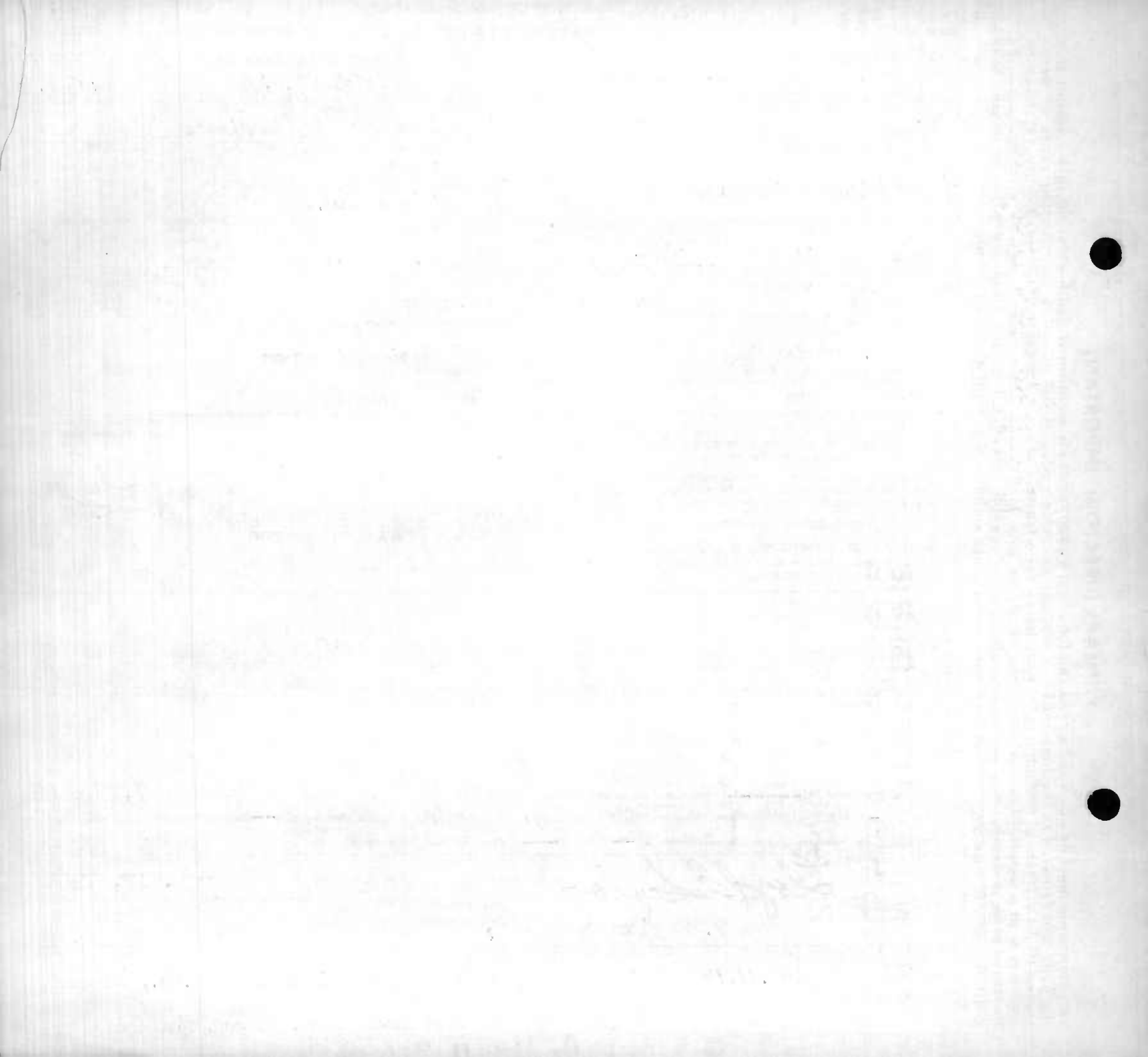
2525 FLEET ST



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">66 10256</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 2em;">66 10256</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Ada Grace Talbott</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 7, 1966</span> <span style="float: right;">6:45 P. M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">90 Ardleigh Nursing Home</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore Co.</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Timonium</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">Gibbons Blvd.</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">June 30, 1884</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">82</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Own Home</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">D. Webster Kyte</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Catherine Zimmerman</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span>	17. INFORMANT <span style="font-size: 1.2em;">Family Records</span>		
18. <span style="font-size: 1.2em;">422.1</span> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Arteriosclerotic cardiovascular disease</span> DUE TO (B) <span style="font-size: 1.2em;">Cerebral arteriosclerosis with senile changes</span> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">10 yrs.</span> <span style="font-size: 1.2em;">20.8</span> <span style="font-size: 1.2em;">3 yrs.</span>
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">March 15</span> <span style="font-size: 1.2em;">1966</span> to <span style="font-size: 1.2em;">October 7</span> , <span style="font-size: 1.2em;">19 66</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">October 4</span> , <span style="font-size: 1.2em;">19 66</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Lloyd E. Saylor</span> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.2em;">Oct. 10, 1966</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Lloyd E. Saylor</span>		23D. ADDRESS <span style="font-size: 1.2em;">3902 Greenmount Avenue</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">Oct. 11, 1966</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Weisburg Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Weisburg, Balto. Co., Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">John Burns' Sons</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">John Burns' Sons, Towson, Maryland</span>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10257</u>	
BIRTH NO. <u>66 10257</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>17</u>		1. NAME OF DECEASED <u>JAMES B. MCINTYRE</u>			
(Type or Print)		2. DATE AND HOUR OF DEATH <u>10-9-66</u> <u>5.15</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> (If not in hospital or institution, give street address or location) <u>1-30-67</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21204 (TOWSON)</u>			
		D. STREET ADDRESS (If rural, give location) <u>516 HOLDEN ROAD</u> <u>53-00</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>6-25-59</u>	9. AGE (In years last birthday) <u>7</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Boy</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland New York</u>	
13. FATHER'S NAME <u>JOHN M. MCINTYRE</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			14. MOTHER'S MAIDEN NAME <u>CHARLOTTE OLSEN</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Family Records</u> ADDRESS		
18. <u>193.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Meduloblastoma in brain</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Meduloblastoma in brain</u> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>10-4-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Meduloblastoma of brain</u>		20A. AUTOPSY (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-30</u> <u>1966</u> to <u>10-9</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>10-9</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louie Uematsu</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>LOUIE UEMATSU</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/10/66</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1966</u>	25B. NAME OF REGISTRAR <u>P. E. E. Taylor</u>	25C. FUNERAL DIRECTOR <u>John Burns Sons, Towson, Maryland</u> ADDRESS			

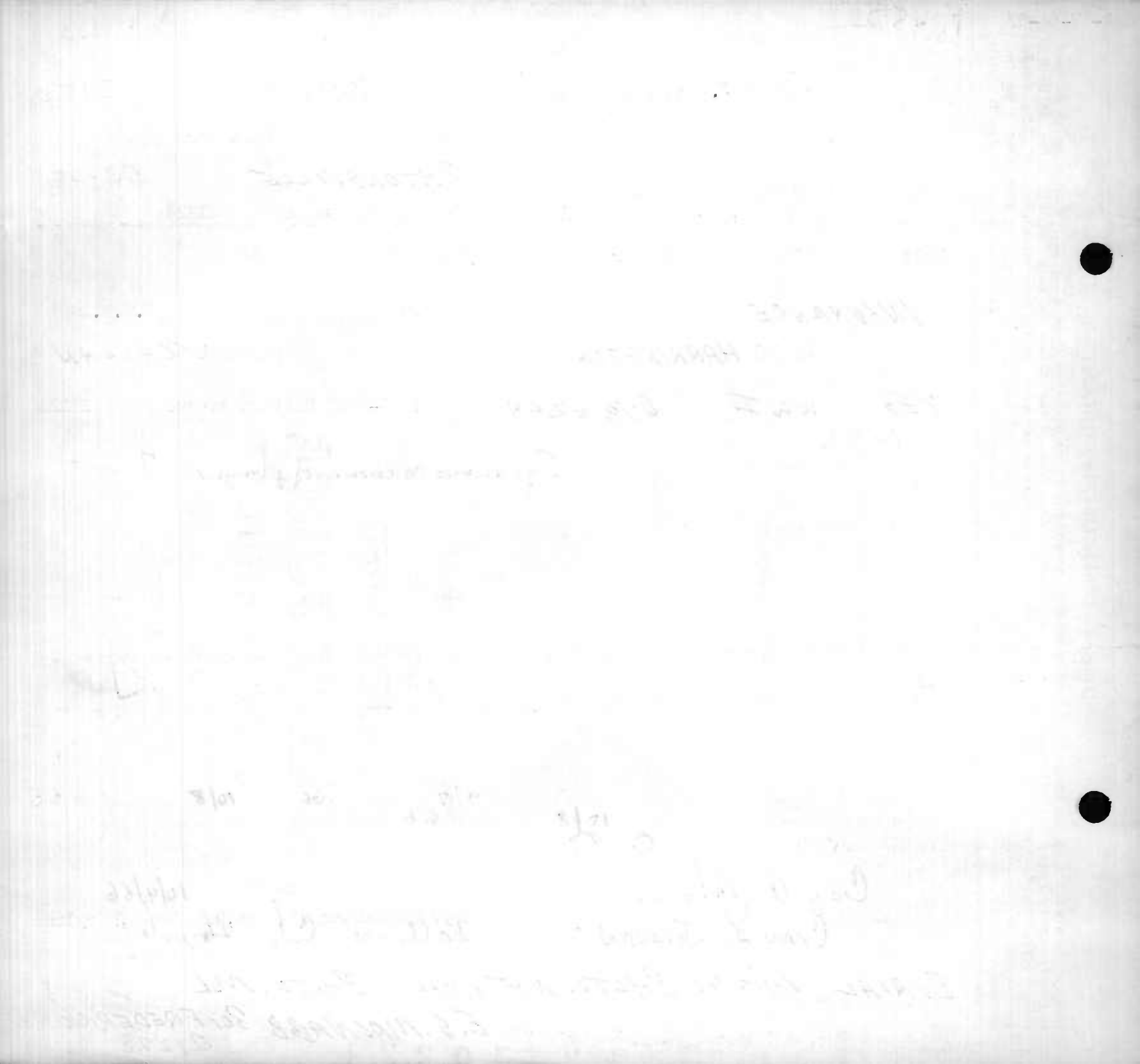


Letter from Union Chem. Corp.  
1-30-67 W.H.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10258		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10258	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John J. Harrington		2. DATE AND HOUR OF DEATH 10/8/66 3:15 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.			
FULL NAME OF HOSPITAL OR INSTITUTION 311 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 53-00			
D. STREET ADDRESS (If rural, give location) 209 Newburg Avenue 21228					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 7/30/1910	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel HARRINGTON		14. MOTHER'S MAIDEN NAME Margaret SCANLAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 073162093		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) 148X I Squamous carcinoma of pharynx		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/7 1966 to 10/8 1966, that (I) (we) last saw the deceased alive on 10/8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Craig A. Johnson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/9/66	
23C. PHYSICIAN'S NAME (Type) CRAIG A. JOHNSON		M.D. 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland Baltimore City Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/12/66		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL	
24D. LOCATION BALTO. MD					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR O. G. E. F. Johnson		25C. FUNERAL DIRECTOR E. S. MACNABB	
				ADDRESS 301 FREDERICK Rd 21228	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such a written approval must be obtained before the remains are embalmed or final disposition is made.

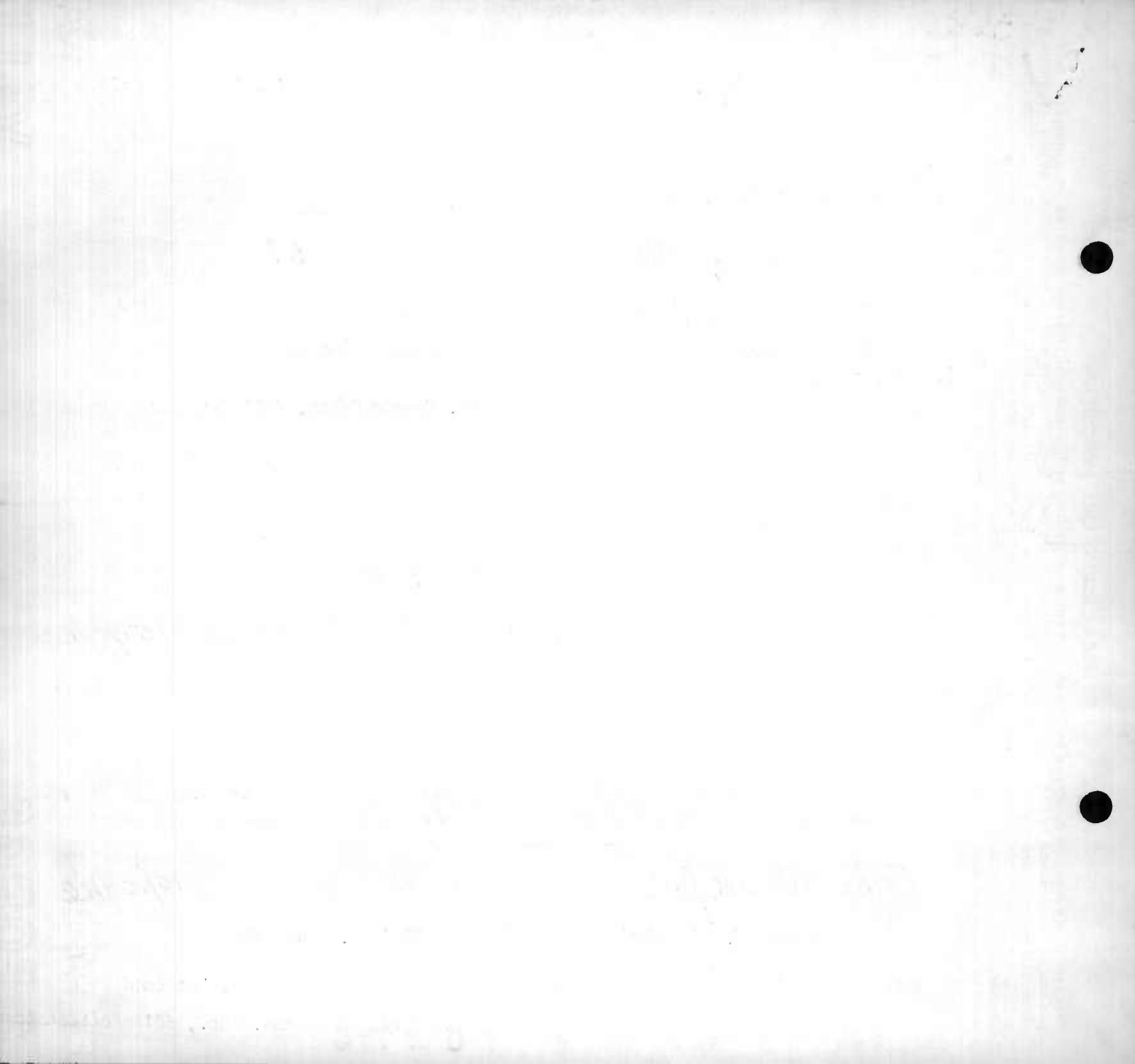
BIRTH NO. 66 10259		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10259	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SADIE MUSKIN		OCTOBER 9, 1966		7:40 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 BELVEDERE NURSING HOME		A. STATE MARYLAND		B. COUNTY Balt. Co.	
		C. CITY OR TOWN BALTIMORE		(If outside city limits, write RURAL and give township) 53-00	
		D. STREET ADDRESS 3405 TERRAPIN ROAD #8			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 15, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GADALH LINSKEY		14. MOTHER'S MAIDEN NAME ANNIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MR. BENJAMIN MUSKIN, 3405 TERRAPIN ROAD #8	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Art. thrombotic Cardio-vas. disease		CAUSE OF DEATH (A) DUE TO Pericardium Cell Sarcoma of Mesentery and small bowel. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 2 1966 to Oct 9 1966, that (I) last saw the deceased alive on Oct 9 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel V. Tompakov		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Oct 9, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 3600 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/11/66		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>66 10260</u>
BIRTH NO. <u>66 10260</u>		<b>CERTIFICATE OF DEATH</b>				
M.E. CASE NO. <u>66 10260</u>						
1. NAME OF DECEASED (Type or Print) <u>Fannie L. Ederr</u>			2. DATE AND HOUR OF DEATH <u>October 10, 1966</u>   <u>8:30 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>90 House In The Pines, Belvedere</u> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-10</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3818 Belle Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Simon Goldberg</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Sugarman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT ADDRESS <u>Mr. Donald Ederr, 4020 Rosecrest Avenue</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>170X I</u> <b>CAUSE OF DEATH</b> <u>CARCINOM of Breast</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>Hypertensive Vascular Disease 15 years</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1950</u> 19 to <u>Oct 10</u> 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Oct 9</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.						
23A. SIGNATURE <u>Albert J. Himelfarb</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/10/66</u>
23C. PHYSICIAN'S NAME (Type) <u>Albert J. Himelfarb</u>				23D. ADDRESS <u>3501 St. Paul Street</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/11/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Moses Montifiore</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>		

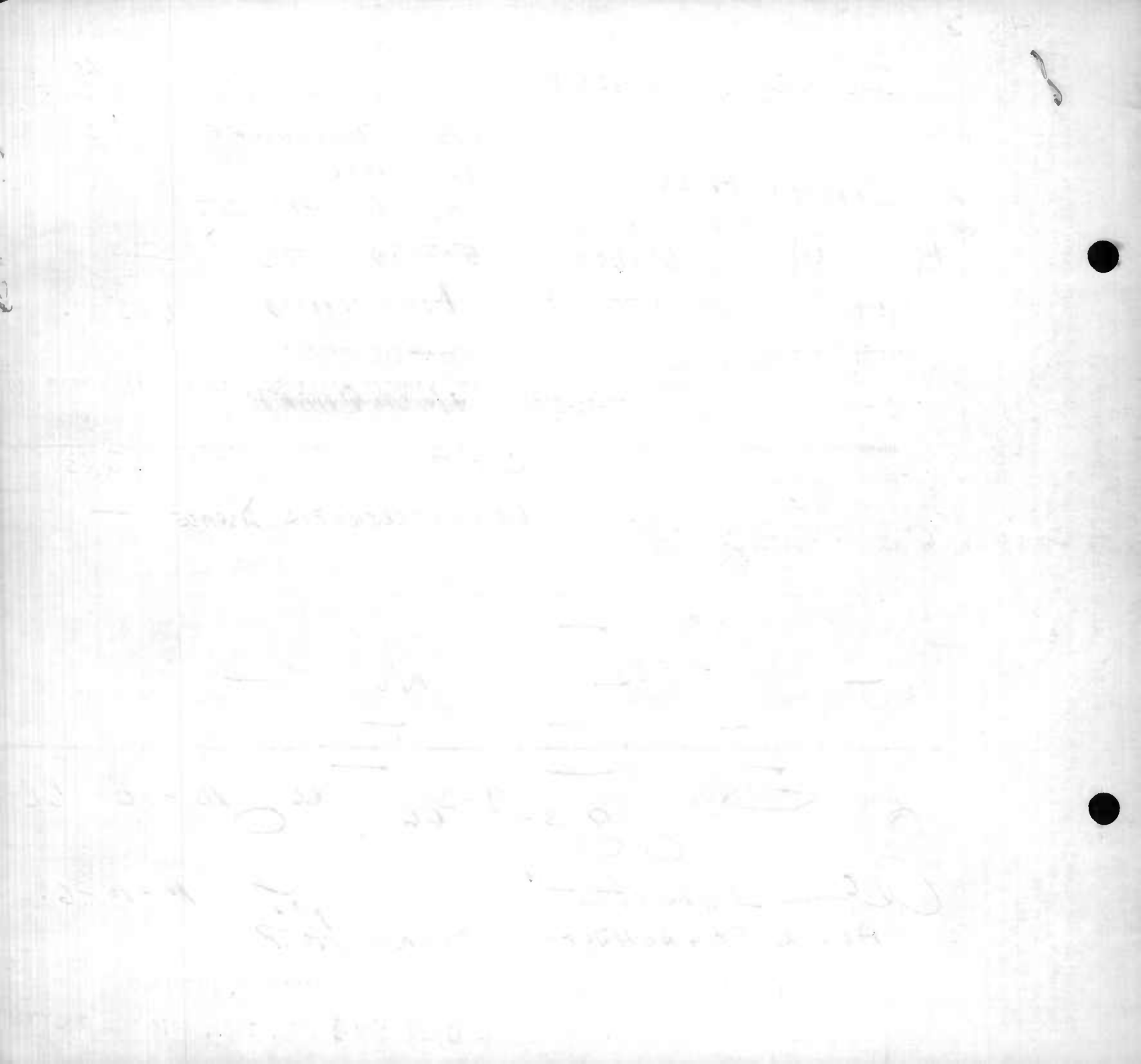




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10261	
BIRTH NO. 66 10261		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ISAAC KALLINSKY		2. DATE AND HOUR OF DEATH 10-10-66 5:20 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1303 W. 41 ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH [REDACTED]	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		10B. KIND OF BUSINESS OR INDUSTRY MUSIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH KALLINSKY		14. MOTHER'S MAIDEN NAME ISABELLE BRANSKY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-18-1074		17. INFORMANT MR. MAURICE KALLINSKY, 4403 DUNLAD ROAD #29	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I CAUSE OF DEATH CVA INTERVAL BETWEEN ONSET AND DEATH 5 WKS.		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. ARTERIOSCLEROTIC DISEASE	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (If this hospital) attended the deceased from 9-3-66 to 10-10-66, that (I) (we) last saw the deceased alive on 9-3-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALVIN SCHACHTER M.D.		23B. DATE SIGNED 10-10-66		23C. PHYSICIAN'S NAME (Type) ALVIN SCHACHTER M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/12/66		24C. NAME OF CEMETERY OR CREMATORY MOSES MONTITORE	
24D. LOCATION BALTIMORE, MARYLAND		24E. ADDRESS 1303 W. 41 ST.		24F. FUNERAL DIRECTOR SOO LEVINSON & BROS. INC., 6010 REISTERSTOWN	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66 10262</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 10262</u>	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Clark, George</u>			Oct 8, 1966 9am M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hosp.</u>			A. STATE <u>Maryland</u> B. COUNTY <u>6-05</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>1501 Tenpin Alley</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/10/91</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Emerson C.</u>			14. MOTHER'S MAIDEN NAME <u>Julia Shipp</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Erlyn Jones 2933 Riggs Rd</u>
18. <u>34031</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  <u>CAUSE OF DEATH</u> (A) <u>Meningitis</u> DUE TO (B) <u>urinary tract infection ?</u> DUE TO (C) <u></u>  INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> 19 <u>66</u> to <u>10/8</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harmon J Eyre</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/8/66</u>
23C. PHYSICIAN'S NAME (Type) <u>Harmon J Eyre</u>			23D. ADDRESS M.D. <u>601 North Broadway Baltimore Md.</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/14/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem</u>	
24D. LOCATION <u>G. A. County, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Joseph J. Block</u>			
25D. ADDRESS <u>1304 N. Central Ave</u>					

Hickster

10/18

Memphis  
University Trust Inspector

yes  
no

10/18

10/2

no

10/18

Harmon I Epic  
Harmon f Epic

10/18/10  
101 North Broadway Baltimore Md  
Joseph ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B 45366 10263		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10263	
<div> <div>13. NAME OF DECEASED (Type or Print)</div> <div>ELsie STANLEY BLAND</div> </div>					
<div> <div>1. NAME OF DECEASED (Type or Print)</div> <div>ELsie STANLEY BLAND</div> </div>					
<div> <div>2. DATE AND HOUR OF DEATH</div> <div>10-10-66 4.30 P.M.</div> </div>					
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div>90 3025 WINDSOR AVE.</div> </div>					
<div> <div>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div> <div>A. STATE</div> <div>MD</div> </div> </div>					
<div> <div>5. CITY OR TOWN (If outside city limits, write RURAL and give township)</div> <div>BALTO.</div> </div>					
<div> <div>6. STREET ADDRESS (If rural, give location)</div> <div>2428 W. LANVALE ST.</div> </div>					
<div> <div>7. SEX</div> <div>F</div> </div>					
<div> <div>8. RACE</div> <div>C.</div> </div>					
<div> <div>9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)</div> <div>WIDOW</div> </div>					
<div> <div>10. DATE OF BIRTH</div> <div>3-23-02</div> </div>					
<div> <div>11. AGE (In years last birthday)</div> <div>64</div> </div>					
<div> <div>12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Housewife</div> </div>					
<div> <div>13. KIND OF BUSINESS OR INDUSTRY</div> <div></div> </div>					
<div> <div>14. BIRTHPLACE (State or foreign country)</div> <div>BALTO, MD</div> </div>					
<div> <div>15. CITIZEN OF WHAT COUNTRY?</div> <div></div> </div>					
<div> <div>16. FATHER'S NAME</div> <div>John Ambrose</div> </div>					
<div> <div>17. MOTHER'S MAIDEN NAME</div> <div>HENRIETTA W. WILLIAMS</div> </div>					
<div> <div>18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>No</div> </div>					
<div> <div>19. SOCIAL SECURITY NO.</div> <div></div> </div>					
<div> <div>20. INFORMANT</div> <div>CONSTANTIA BANKS</div> </div>					
<div> <div>21. ADDRESS</div> <div>219 DENISON ST</div> </div>					
<div> <div>22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>174X I Carcinoma of the uterus</div> </div>					
<div> <div>23. ANTECEDENT CAUSES</div> <div></div> </div>					
<div> <div>24. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div></div> </div>					
<div> <div>25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> <div></div> </div>					
<div> <div>26. MEDICAL CERTIFICATION</div> <div></div> </div>					
<div> <div>27. DATE OF OPERATION</div> <div></div> </div>					
<div> <div>28. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div></div> </div>					
<div> <div>29. AUTOPSY? (Yes or No)</div> <div></div> </div>					
<div> <div>30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> <div></div> </div>					
<div> <div>31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</div> <div></div> </div>					
<div> <div>32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> <div></div> </div>					
<div> <div>33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> <div></div> </div>					
<div> <div>34. TIME OF INJURY (APPROX.)</div> <div></div> </div>					
<div> <div>35. INJURY OCCURRED</div> <div>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div> </div>					
<div> <div>36. HOW DID INJURY OCCUR?</div> <div></div> </div>					
<div> <div>37. I certify that (I) (this hospital) attended the deceased from 9/17/66 to 10/10/66, that (I) (we) last saw the deceased alive on 10/10/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> </div>					
<div> <div>38. SIGNATURE</div> <div>Alvin Thompson</div> </div>					
<div> <div>39. DATE SIGNED</div> <div>10/12/66</div> </div>					
<div> <div>40. PHYSICIAN'S NAME (Type)</div> <div>Alvin Thompson</div> </div>					
<div> <div>41. ADDRESS</div> <div>1856 N. Wolfe St. Baltimore, Md. 21213</div> </div>					
<div> <div>42. BURIAL CREMATION, REMOVAL (Specify)</div> <div>REMOVAL</div> </div>					
<div> <div>43. DATE</div> <div>10/13/66</div> </div>					
<div> <div>44. NAME OF CEMETERY or CREMATORY</div> <div>MT. CALVARY</div> </div>					
<div> <div>45. LOCATION (City, town, or county) (State)</div> <div>A.A. County, Md</div> </div>					
<div> <div>46. DATE REC'D BY HEALTH DEPT.</div> <div>OCT 12 1966</div> </div>					
<div> <div>47. NAME OF REGISTRAR</div> <div>R. E. E. F. E. E.</div> </div>					
<div> <div>48. FUNERAL DIRECTOR</div> <div>Joseph J. R. R. R.</div> </div>					
<div> <div>49. ADDRESS</div> <div>1504 N. Central Ave</div> </div>					

Alfred  
V. B. B. B.  
C. B.

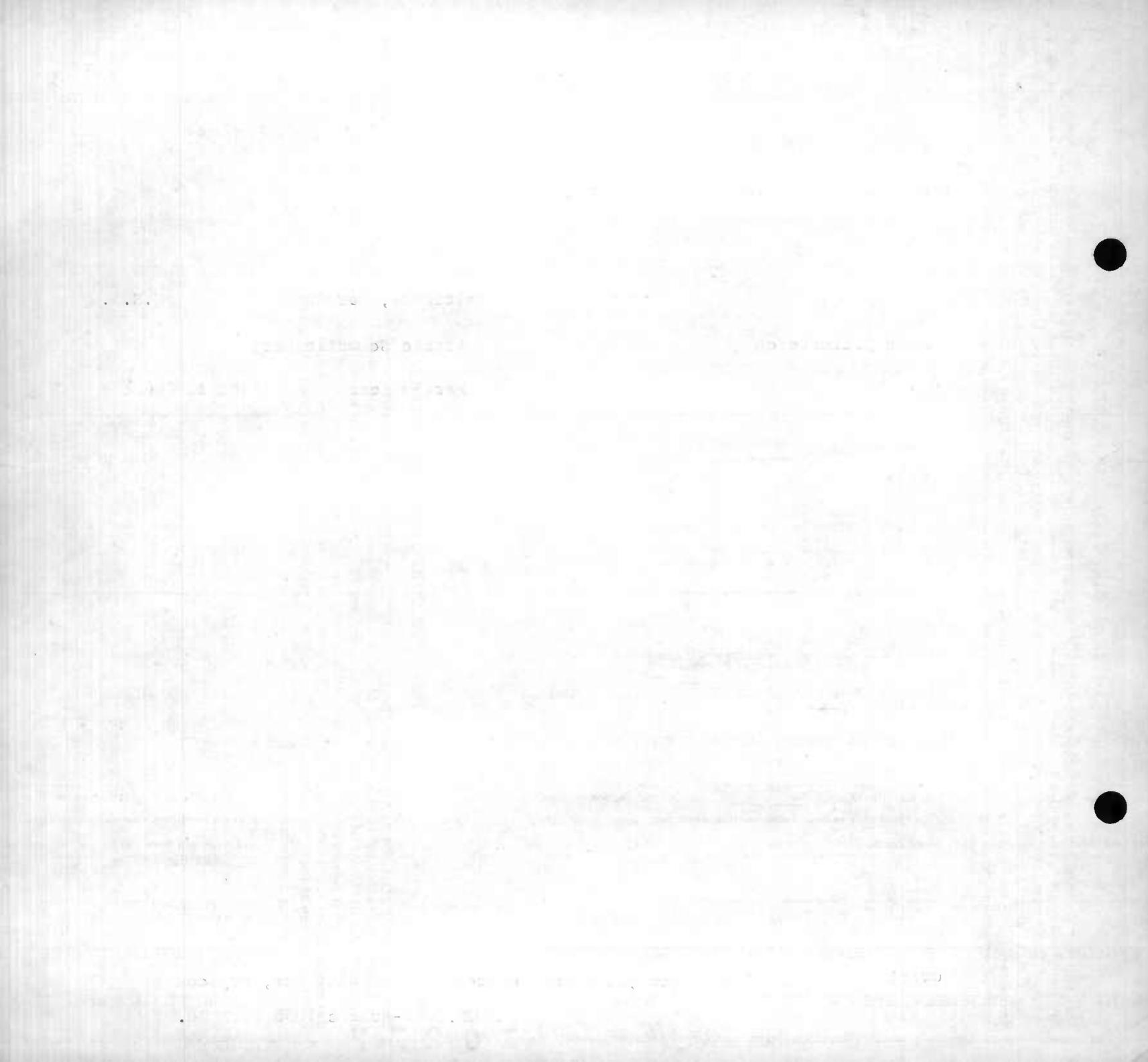
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10264		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 10264	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ACHES ELIZABETH ZENO</b>			2. DATE AND HOUR OF DEATH <b>10/11/66 1:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 14-03</b> D. STREET ADDRESS (If rural, give location) <b>PARK HILL NURSING HOME</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4/29/42</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Dotterweich</b>			14. MOTHER'S MAIDEN NAME <b>Lizzie Schwallenberg</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-22-2777</b>	17. INFORMANT <b>Martin Kerr</b>		ADDRESS <b>54 Comst Court</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>INTRACEREBRAL HEMORRHAGE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>FRACTURE LEFT FEMUR</b>					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/13/1966</b> to <b>10/11/1966</b> , that (I) (we) lost saw the deceased alive on <b>10/10/1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John P Doerfer</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>10/11/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN P DOERFER</b>			23D. ADDRESS <b>MARYLAND GENERAL HOSPITAL</b>		
24A. REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>WM. Cook-Brooks 1050 York Rd.</b>	
				ADDRESS	

OCT 12 1966 **W. Cook-Brooks** 3 0 2 7 7

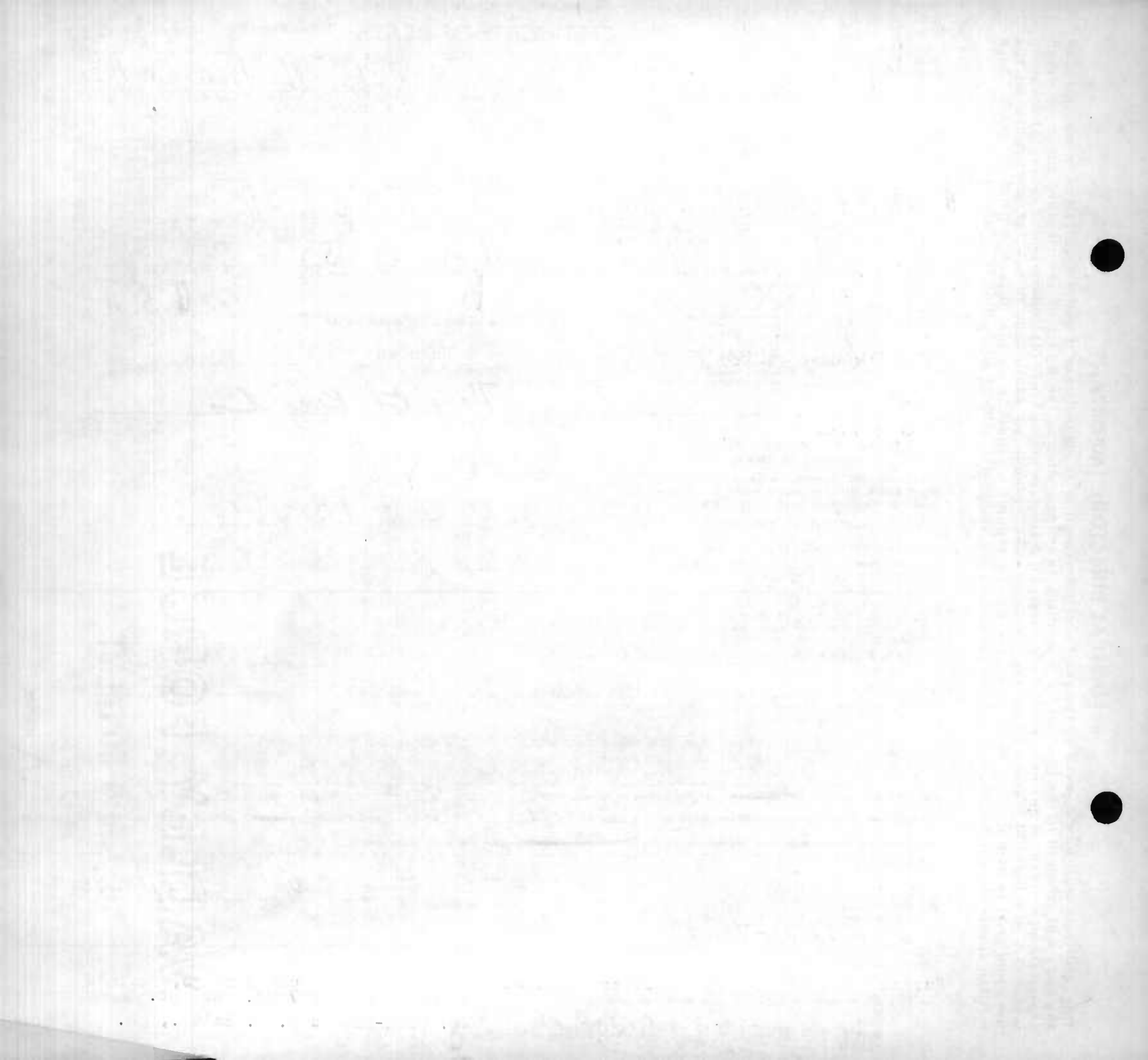




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 10265	
BIRTH NO. 66 10265		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BECK RUTH (Thelma)</b>		2. DATE AND HOUR OF DEATH <b>October 11 - 1966 10<sup>15</sup> PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>North Charles General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>12-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2110 North Charles St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11-26-07</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b><del>Thelma Beck</del> - Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>5-77-18-3784</b>		17. INFORMANT <b>Hospital Record</b> ADDRESS			
18. I <b>5-81.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cirrhosis of the liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Severe Gastrointestinal bleeding</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <b>7-30-1966</b> to <b>Oct 11 - 1966</b> , that (I) (we) lost saw the deceased alive on <b>Oct 11</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Thelma Beck</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-11-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Kangle</b>		23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Calvary Baptist</b>		24D. LOCATION (City, town, or county) (State) <b>Millboro Springs, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>1217 St. Paul St. ADDRESS</b> <b>Wm. Cook-Brooks F. H. Balto., Md.</b>			



66 10266

BALTIMORE CITY HEALTH DEPARTMENT

66 10266

BIRTH NO. 66-10753

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CONSETTA M. ALVEZ

2. DATE AND HOUR PRONOUNCED DEAD

October 11, 1966

2:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street  
address or location)

City Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

703 Old Northpoint Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

5-24-1966

9. AGE (In years  
last birthday)

4 mos.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

4 mths

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Alvez

14. MOTHER'S MAIDEN NAME

PORSHA

UNDERWOOD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

EDWARD K. ALVEZ 703 OLD NORTH PT. RD.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoma, etc. It means the disease,  
injury or complication which caused death.)Interstitial Pneumonitis (SDII)  
Acute bronchopneumonia (SDII)

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 12, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-14-1966

23C. NAME of CEMETERY or CREMATORY

OAK LAWN CEM.

23D. LOCATION

BALTO

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 12 1966 P.D. &amp; E. Fairbank

JOHN M. WEBER &amp; SONS INC 401 S. CHESTER ST

VALLEY FORCE

PAC CONTENT

2-11-66

2-11-66

2-11-66

2-11-66

2-11-66

2-11-66

2-11-66

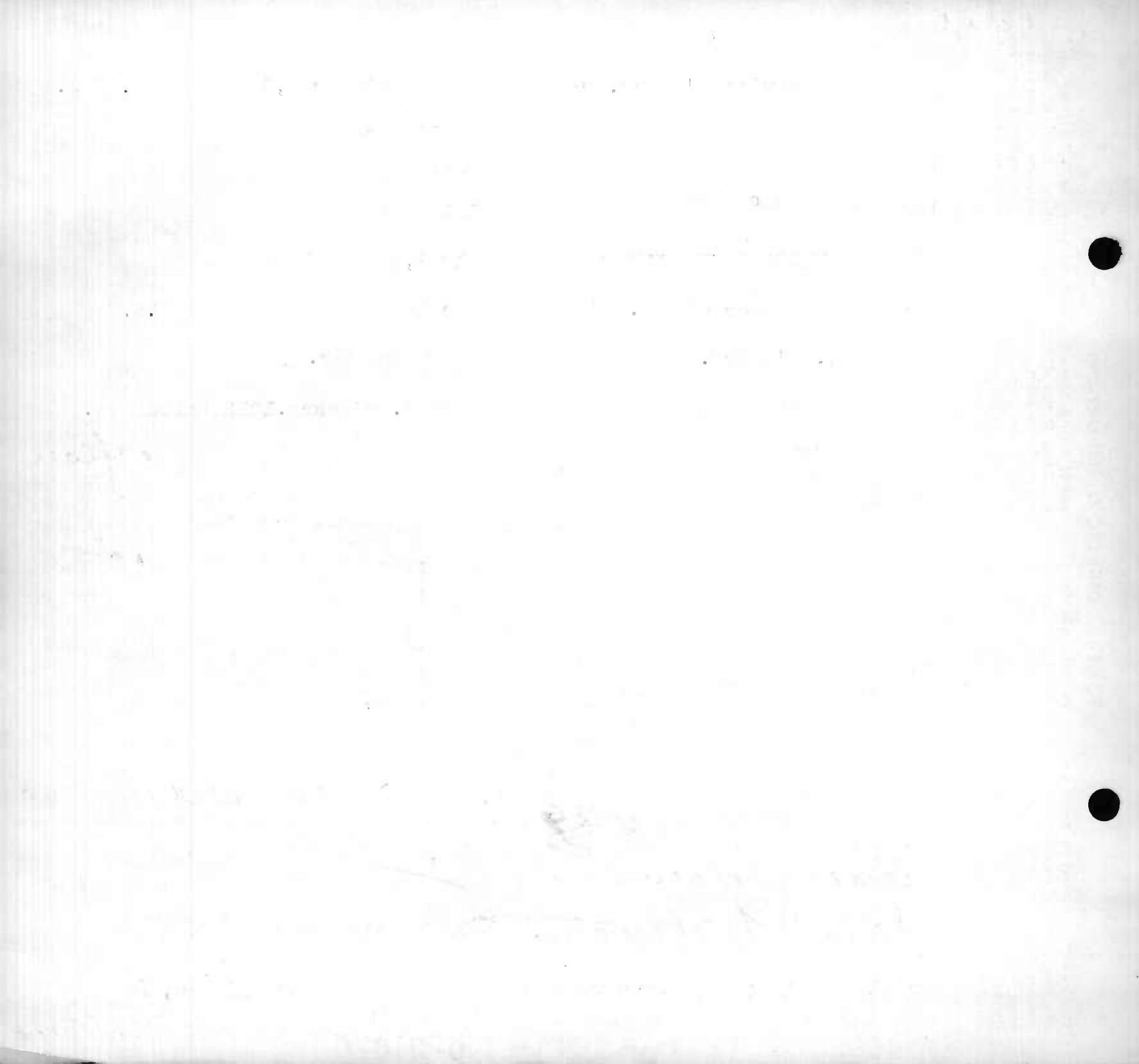
2-11-66

2-11-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10267</u>	
BIRTH NO. <u>66 10267</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Charles O'Leary, Sr</u>		2. DATE AND HOUR OF DEATH <u>October 9, 1966</u>   <u>9.20 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>13-07</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1012 Union Ave</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1012 Union Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>July 3, 1896</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brick Layer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>John T. O'Leary</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>John T. O'Leary.</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Taylor.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Sadie R. O'Leary. 1012 Union Ave.</u>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiovascular Disease</u> <u>Congestive failure</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>54 years</u> <u>1 day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 10 1962</u> to <u>Oct 10 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 9 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>LEONARD W. ALLENSTEIN</u> M.D.				23B. DATE SIGNED <u>10/11/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leonard Wallenstein</u> M.D.		23D. ADDRESS <u>848 W 36th St</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/12/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>	
				24D. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1966</u>		25B. NAME OF REGISTRAR <u>P. E. E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Quentin E. Donovan</u> ADDRESS <u>3818 Roland Ave</u>	





D-400

66 10268

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 10268

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARIE DAILEY

2. DATE AND HOUR PRONOUNCED DEAD

October 8, 1966

P.M.

3:10-A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

10-20-66

Church Home Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

2-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2001 E. Pratt Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

UNK

8. DATE OF BIRTH

5-29-1925

9. AGE (In years  
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

UNKNOWN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. M.D.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

BERNARD K. DAILEY

14. MOTHER'S MAIDEN NAME

CARRIE THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

BK. DAILEY

1615 DODD LITTLE RD

18. 322.0 I

CAUSE OF DEATH

Acute Alcoholism

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty metamorphosis of liver -  
DUE TO

(B) DUE TO

(C) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-12-66

23C. NAME of CEMETERY or CREMATORY

OAK LAWN

23D. LOCATION

BALTO.

(City, town, or county)

(State)

M.D.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Connelly Sons

300 Mace

OCT 12 1966

30281

Letter from M.E.'s office

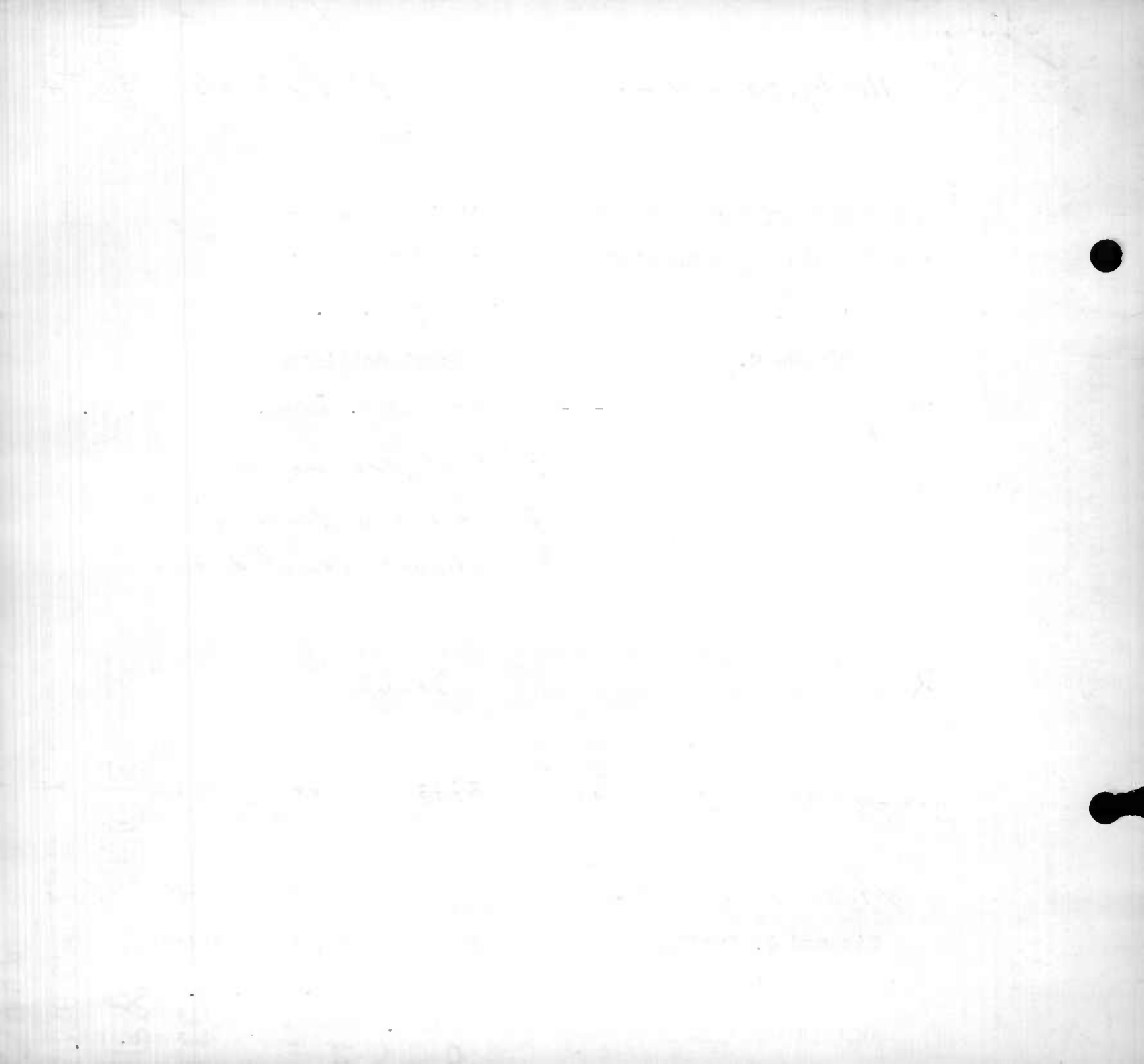
10-20-66

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10269	
BIRTH NO. 66 10269		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Hurley, Edward L.</i>		2. DATE AND HOUR OF DEATH <i>10/10/66 1 5<sup>25</sup> A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Montgomery Co</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Damascus 65-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>27505 Ridge Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>7/28/13</i>	9. AGE (In years lost birthday) <i>53</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>General store</i>		11. BIRTHPLACE (State or foreign country) <i>Damascus, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Claude C.</i>		14. MOTHER'S MAIDEN NAME <i>Ethel Bellison</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-03-0551</i>		17. INFORMANT ADDRESS <i>Mrs Anne E. Hurley, Damascus, Md.</i>	
18. <i>446X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostemia, etc. It means the disease, injury or complication which caused death.) <i>Bilateral pneumonia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>5 severe underlying</i> <i>hypertensive renal disease</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9/23 1966</i> to <i>10/10 1966</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>10/10 1966</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> view the body after death.					
23A. SIGNATURE <i>Richard J. Owellen</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard J. Owellen</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/12/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Pine Grove</i>	
24D. LOCATION (City, town, or county) (State) <i>Mt. Airy, Md.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Olin L. Molesworth, Damascus, Md.</i>			



BIRTH NO.

66 10270

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10270

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MICHAEL LEDFORD

2. DATE AND HOUR PRONOUNCED DEAD

October 11, 1966 9:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 28-04

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4725 Amberly Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

Oct-30-1886

9. AGE (In years  
last birthday)

81

If Under 1 Yr, If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Iron Worker

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Canada

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George Ledford

14. MOTHER'S MAIDEN NAME

Annie Mahoney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Catherine Anderson - Bell Flower Cal

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 12, 1966

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/15/66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Thomas J. Kennedy Baltimore Md

OCT 12 1966

10-15-66

10-15-66

10-15-66

10-15-66

WALLACE FORBES  
PAID COPY

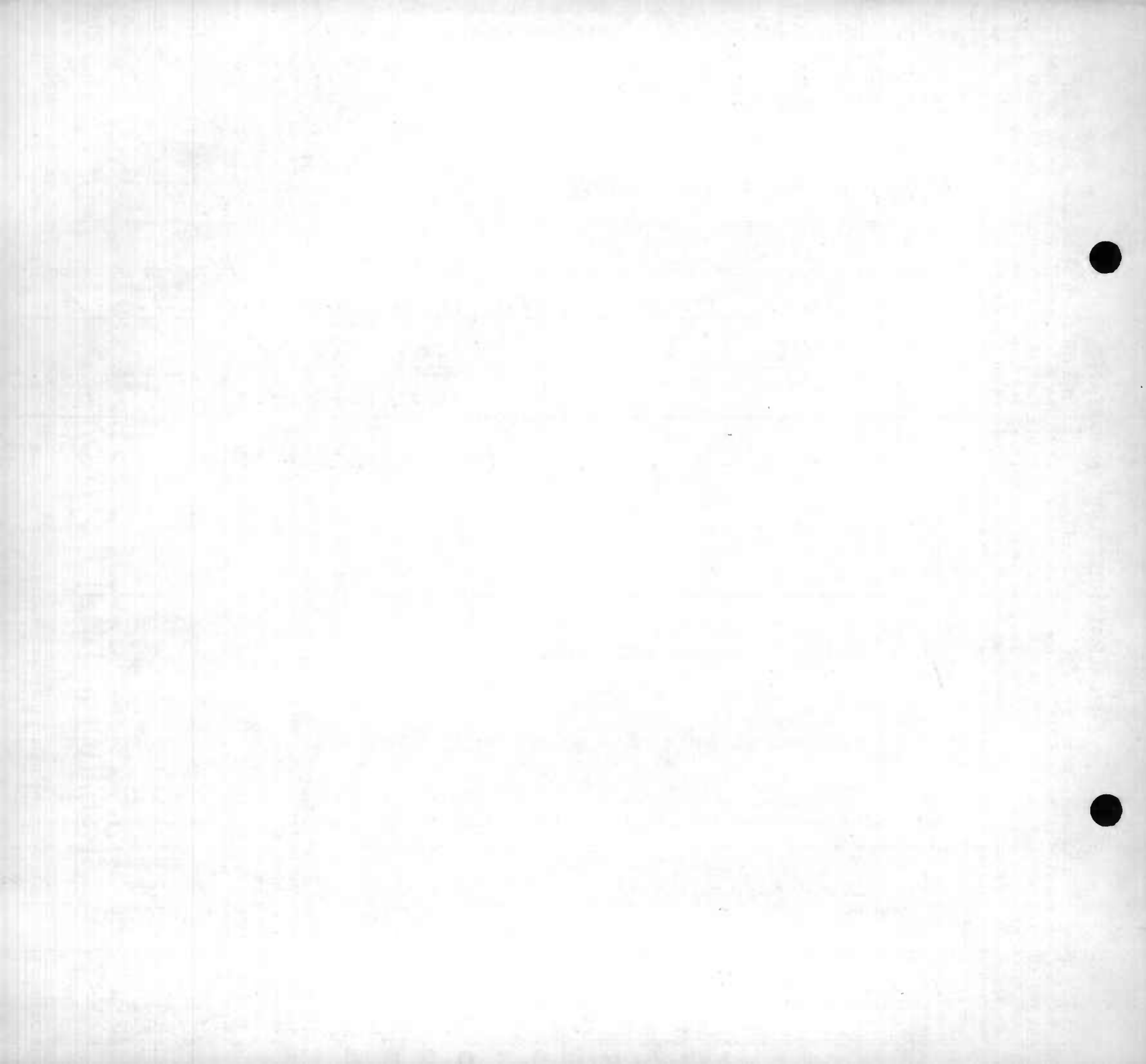


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 10271	
BIRTH NO. 66 10271		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN F. BELL SR		2. DATE AND HOUR OF DEATH OCTOBER 11, 1966 11 31 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
42 SINAI HOSP. OF BALTIMORE, INC.		MARYLAND BALTIMORE C.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 53-00			
		D. STREET ADDRESS (If rural, give location)			
		3845 WOODSIDE AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH AUG. 8, 1907	9. AGE (In years last birthday) 59 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ENGINEER ASST.		TELEPHONE COMP.		BALTIMORE, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN ALBERT BELL		MARY KELLY		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		218-09-2312		JOHN F. BELL, JR. 3845 WOODSIDE AVE. BALT., Md.	
18. 420.1 I		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Acute Myocardial Infarction			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
SEPT. 23, 1966		BENIGN PROSTATIC HYPERTROPHY		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 22, 1966 to OCTOBER 11, 1966, that (I) (we) lost saw the deceased alive on OCTOBER 11, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D.		23B. DATE SIGNED	
Francisco L. Sabado, Jr.				OCTOBER 11, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		SINAI HOSP. OF BALT.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		10/15/66		Parkwood Cemetery	
				BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 12 1966		D. B. E. Fulkerson		Chas. F. Evans & Son 8802 Hartford Rd	

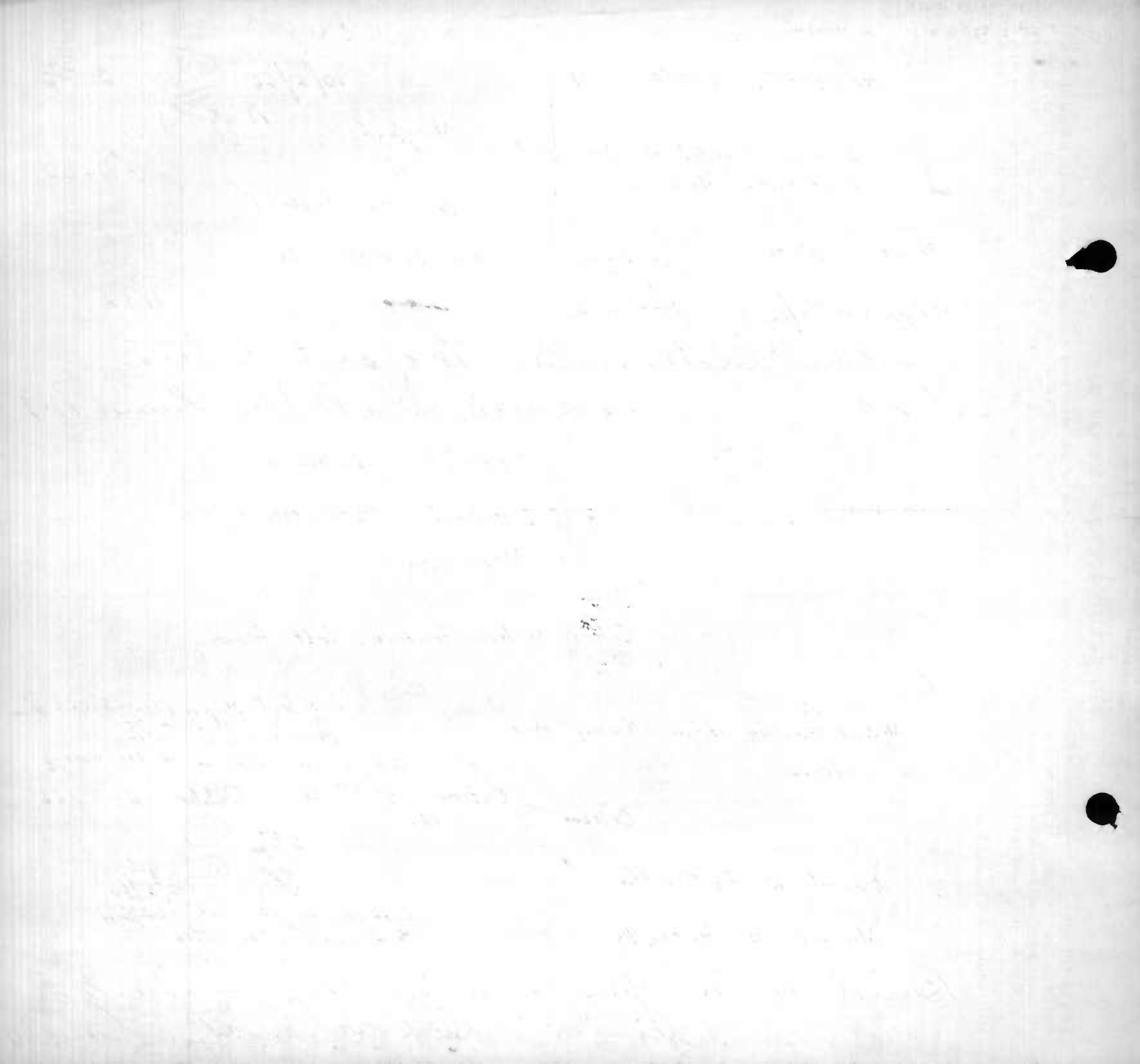




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 10272	
BIRTH NO. 66 10272		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEISBERT, IRENE M.	
2. DATE AND HOUR OF DEATH 10/6/66 2 27 P M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland Baltimore, Md. 21216		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY B. & C. CITY OR TOWN (If outside city limits, write RURAL and give township) Laurel C. 62-00 D. STREET ADDRESS (If rural, give location) Box 104 Route 1			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) Widowed	8. DATE OF BIRTH Nov. 17, 1880	9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (State or foreign country) U.S.A. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Fletcher Miller	
14. MOTHER'S MAIDEN NAME Margaret Waters		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-03-26541	
17. INFORMANT Mrs. Miller Laurel Md		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH	
INTERVAL BETWEEN ONSET AND DEATH		Electrolyte Imbalance		Intestinal Obstruction	
MEGA COLON		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Enter fracture, left femur		20. DATE OF OPERATION 10/5/66	
21. CONDITION FOR WHICH OPERATION WAS PERFORMED		22. AUTOPSY? (Yes or No) No		23. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Medical Examiner notified		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home		26. WHERE DID INJURY OCCUR? Duke Land Nursing & Convalescent Home 1501 N. Duke Land St. Baltimore, Md. 21216	
27. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 10/5/66		28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		29. HOW DID INJURY OCCUR? Fell in the bathroom of the nursing home	
30. I certify that (I) (this hospital) attended the deceased from October 5 1966 to October 6 1966, that (I) (we) last saw the deceased alive on October 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 2 27 PM					
31. SIGNATURE Manuel G. Fontanilla		32. DATE SIGNED 10/6/66		33. PHYSICIAN'S NAME (Type) Manuel G. Fontanilla	
34. ADDRESS Lutheran Hospital of Maryland Baltimore, Md. 21216		35. BURIAL CREMATION, REMOVAL (Specify) Burial		36. DATE 10-8-66	
37. NAME of CEMETERY or CREMATORY Glen Haven Cem		38. LOCATION (City, town, or county) Glen Burnie Md		39. DATE REC'D BY HEALTH DEPT. OCT 12 1966	
40. NAME OF REGISTRAR		41. FUNERAL DIRECTOR		42. ADDRESS	



W-420

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 10273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10273

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Robert Welsh

2. DATE AND HOUR PRONOUNCED DEAD

October 15 66 5:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Howard Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Jessup

D. STREET ADDRESS (If rural, give location)

Route 1 Box 128

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

May 16, 1910

9. AGE (in years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

furniture repairman

10B. KIND OF BUSINESS OR INDUSTRY

National Plastic Industry

11. BIRTHPLACE (State or foreign country)

Front Hill, Va

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Tom Welsh

14. MOTHER'S MAIDEN NAME

Frances Sealack

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mary Knisley, Savage, Md.

ADDRESS

18.

4221 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) arteriosclerotic cardio-vascular disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct. 2nd 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-5-66

23C. NAME OF CEMETERY or CREMATORY

Savage Cem

23D. LOCATION

(City, town, or county)

Savage Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 12 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

W. Witt Sanadon Funeral Hse

ADDRESS

1914 MAY 10

2

May 10

Mr. J. H. ...

...

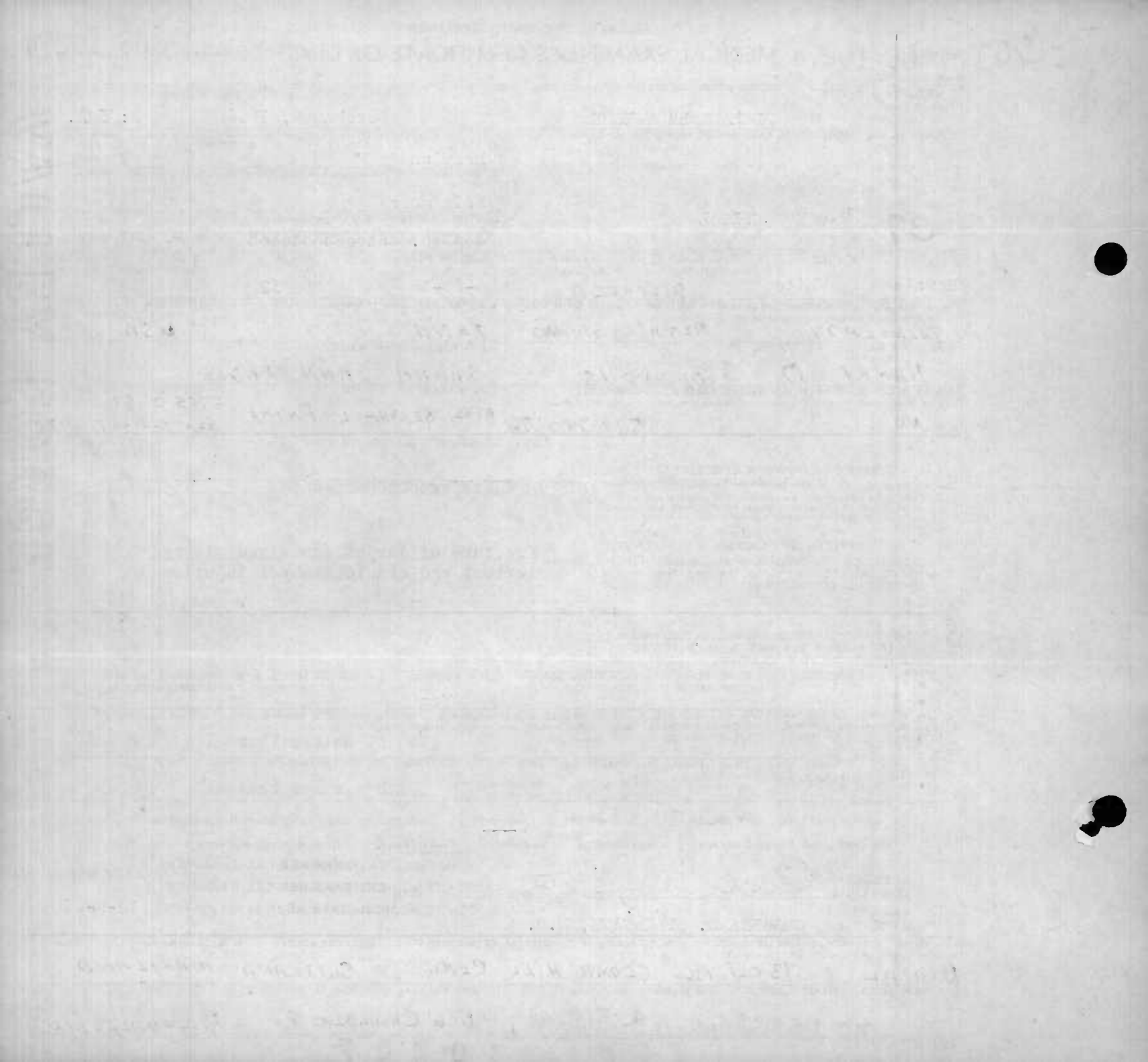
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 10275	
<div> <div>BIRTH NO. 66 10275</div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print) <i>Swerdloff, Sol</i></div> <div>2. DATE AND HOUR OF DEATH <i>10/2/66 2:30 P.M.</i></div> </div>											
<div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i></div> <div>(If not in hospital or institution, give street address or location)</div> </div>						<div>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</div> <div> <div>A. STATE <i>Maryland</i></div> <div>B. COUNTY <i>27-15</i></div> </div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i></div> <div>D. STREET ADDRESS (If rural, give location) <i>2232 Crest Road 21209</i></div>					
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>MARCH 29, 1891</i>		9. AGE (In years lost birthday) <i>75</i>		<div>If Under 1 Yr. Months Days</div> <div>If Under 24 Hrs. Hours Min.</div>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retail</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Merchant</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Matthew Swerdloff</i>						14. MOTHER'S MAIDEN NAME <i>Esther ?</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-32-0076</i>		17. INFORMANT ADDRESS <i>Mrs. Anne Swerdloff, 2232 Crest Road #9</i>					
<div>18. <i>443X1</i></div> <div>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</div> <div>CAUSE OF DEATH <i>Cerebral thrombosis</i></div> <div>INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i></div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div><i>Hypertensive Cardiovascular disease ? years</i></div>											
<div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div>											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
<div>22. I certify that (I) (this hospital) attended the deceased from <i>9/29</i> 19 <i>66</i> to <i>10/2</i> 19 <i>66</i>.</div> <div>that (I) (we) last saw the deceased alive on <i>10/2</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>											
23A. SIGNATURE <i>R. L. Young, Jr.</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>								23B. DATE SIGNED <i>10/2/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>R. L. Young, Jr.</i>				23D. ADDRESS M.D. <i>Sinai Hospital</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/4/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Mikro Kodesh Beth Israel</i>				24D. LOCATION (City, town, or county) (State) <i>Randallstown, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS <i>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</i>			

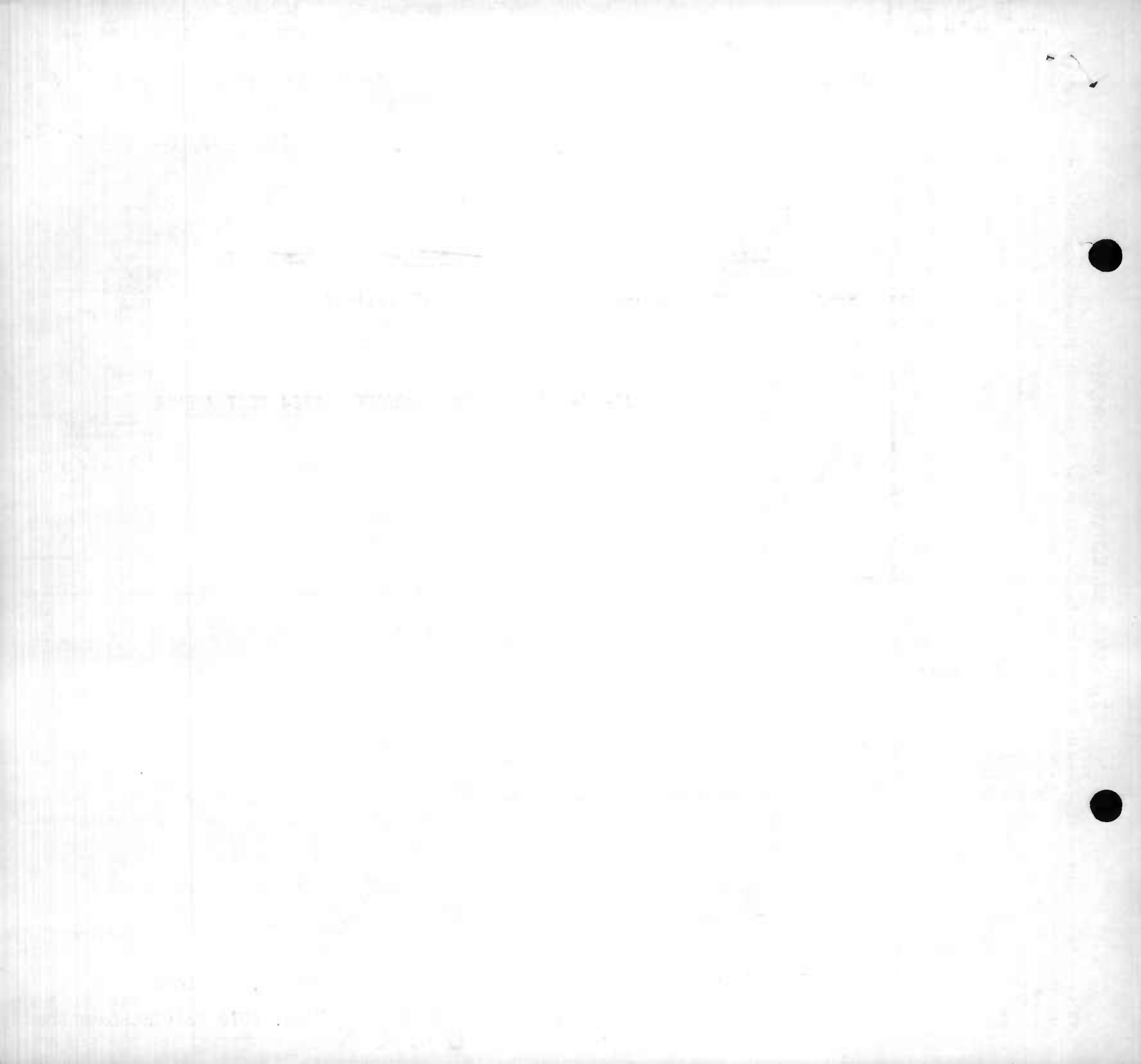
OCT 12 1966

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

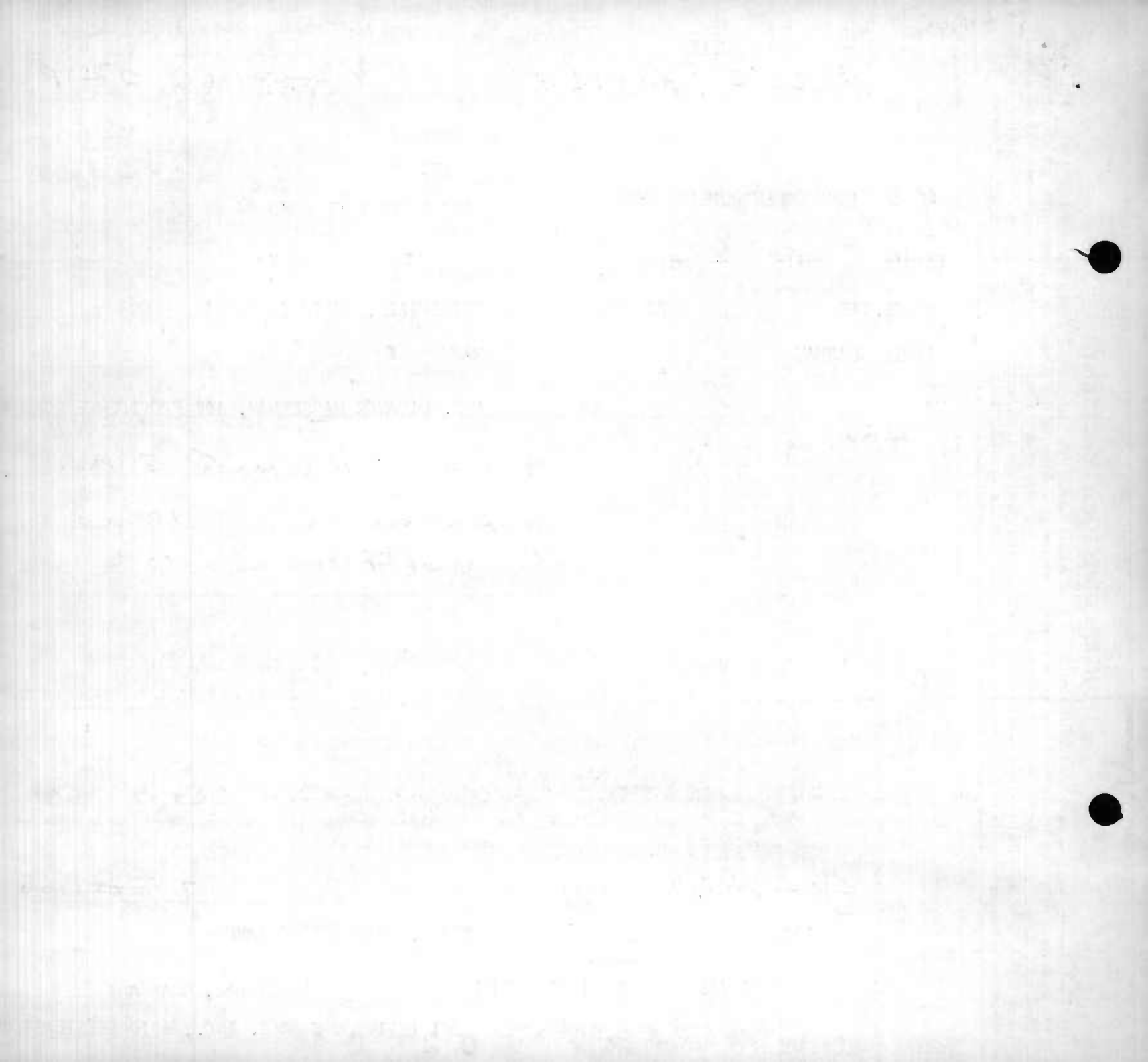
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 10276					CERTIFICATE OF DEATH		Registered No. 66 10276		
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <i>Max Buchoff</i>					2. DATE AND HOUR OF DEATH <i>Oct. 8th 1966 7.25 P. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Sinai Hospital of Baltimore</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> <i>27-20</i>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					D. STREET ADDRESS (If rural, give location) <i>6223 Woodcrest Ave</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <del>*****</del>	9. AGE (In years last birthday) <del>*****</del> <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CONTRACTOR</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>COATS</i>		11. BIRTHPLACE (State or foreign country) <i>***** Latvia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>UNKNOWN</i>					14. MOTHER'S MAIDEN NAME <i>EVA ?</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>215-12-4239</i>		17. INFORMANT <i>JOSEPH BUCHOFF</i>			ADDRESS <i>5334 GIST AVENUE</i>	
18. <i>204.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Pericardial effusion</i> DUE TO (B) <i>Chronic Lymphocytic Leukemia</i> DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>Un Known</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic bronchitis and emphysema</i>					<i>Un Known</i>				
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 23</i> 19 <i>66</i> to <i>Oct 8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Oct. 8th</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>W. Cieplinski</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>8/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>William Cieplinski</i>					23D. ADDRESS <i>Sinai Hospital of Baltimore</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/8/1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Workmen Circle</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 12 1966</i>			25B. NAME OF REGISTRAR <i>Paul E. Farkas</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Sol Levinson &amp; Bros. 6010 Reisterstown Road</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10277	
BIRTH NO. 66 10277		HELEN		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MOLLIE FRANKLIN</b>		2. DATE AND HOUR OF DEATH <b>7 <del>SEP</del> 1966 1230 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 LONG GREEN NURSING HOME</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b> D. STREET ADDRESS (If rural, give location) <b>602 PROVIDENCE ROAD #4</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH	9. AGE (in years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>REIDSVILLE, NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LOUIS BEARMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MRS. ELEANOR WASSERMAN, 602 PROVIDENCE ROAD #</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				INTERVAL BETWEEN ONSET AND DEATH	
(A) <b>Myocardial infarct</b>				<b>5 yrs.</b>	
(B) <b>Hypertension</b>				<b>10 yrs.</b>	
(C) <b>Cerebral thrombosis</b>				<b>10 day</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 10 1952</b> to <b>OCT 7 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT 6 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph D B King</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>7 <del>SEP</del> 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH KING</b>		23D. ADDRESS <b>222 W. COLD SPRING LANE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS. INC.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>6010 REISTERSTOWN</b>	

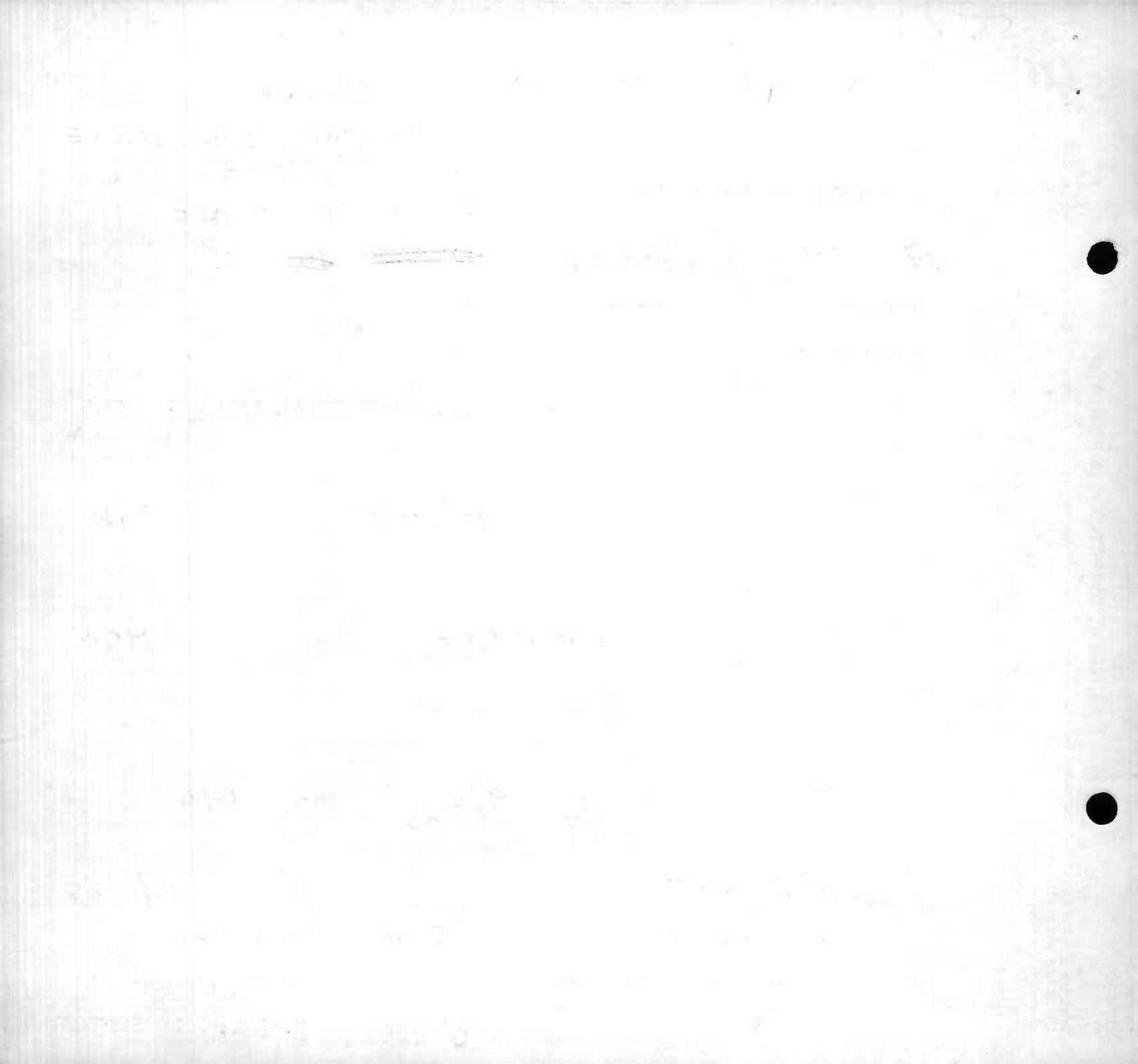


**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10278</u>	
BIRTH NO. <u>66 10278</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>SEAMAN, ABRAHAM</u>		2. DATE AND HOUR OF DEATH <u>10/6/66</u> <u>12:20 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u>		A. STATE <u>MARYLAND</u> , B. COUNTY <u>BALTIMORE</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>2804 SMITH AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>[REDACTED]</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>	
13. FATHER'S NAME <u>KOPPEL SEAMAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. TILLIE SEAMAN, 2804 SMITH AVENUE #9</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. If means the disease, injury or complication which caused death.) <u>ASHD</u>		CAUSE OF DEATH (A) <u>M1</u> DUE TO (B) <u>ASHD</u> DUE TO (C) <u>1946</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MON</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>PNEUMONIA</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9/6</u> <u>1966</u> to <u>10/6</u> <u>1966</u> , that (1) (we) last saw the deceased alive on <u>10/6</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>D.A. SPOTT</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/9/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MOGAN ABRAHAM</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1966</u>			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>SOB LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</u>			

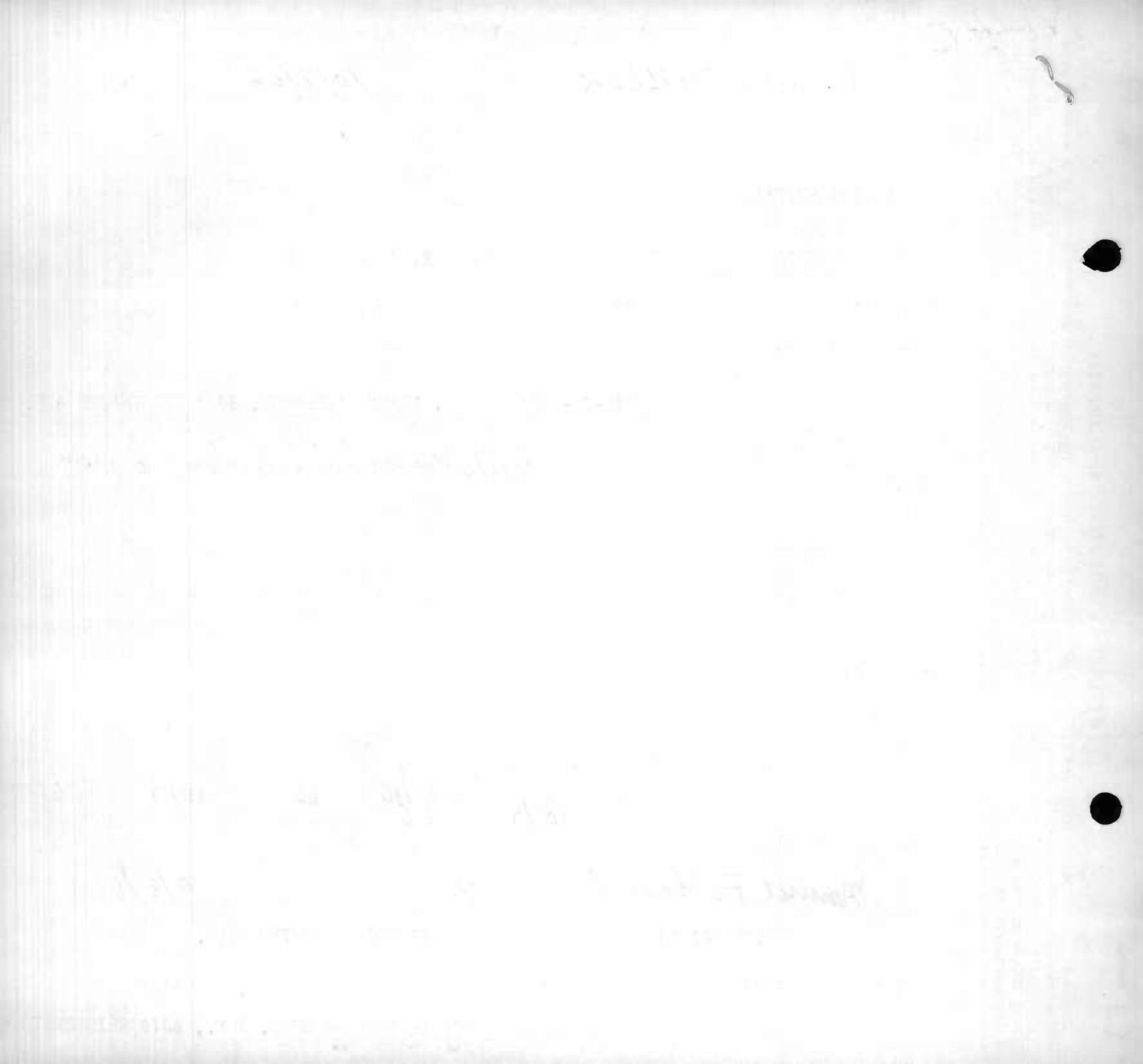




FUNERAL DIRECTOR: IMPORTANT

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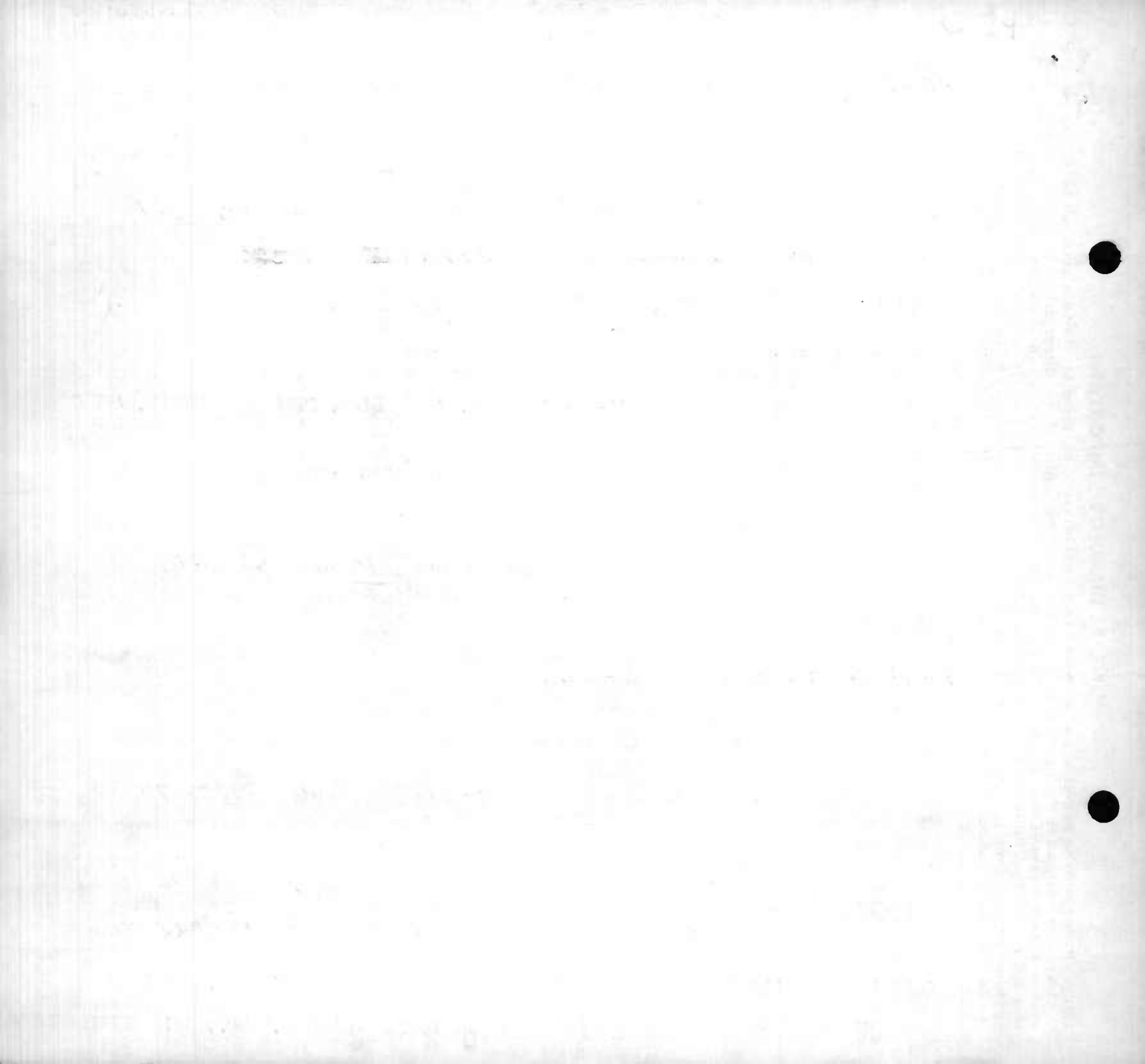
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10279</span>	
BIRTH NO. <span style="float: right;">66 10279</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MILDRED C. MILLER</b>		2. DATE AND HOUR OF DEATH <b>10/7/66</b>   <b>3:45 P</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b>   B. COUNTY <b>27-20</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3208 GLEN AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>JUNE 22, 1906</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months:   Days:   If Under 24 Hrs. Hours:   Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>HARRY FLEISHMAN</b>			
14. MOTHER'S MAIDEN NAME <b>EVA KRONBERG</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>212-18-8808</b>		17. INFORMANT ADDRESS <b>MR. FRANK FLEISHMAN, 3000 STRATHMORE AVE.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>none</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>60</b> to <b>10/7</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Maurice Feldman</b> M.D.				23B. DATE SIGNED <b>10/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAURICE FELDMAN</b> M.D.				23D. ADDRESS <b>6610 CROSS COUNTRY BLVD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BNAI ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1966</b>		25B. NAME OF REGISTRAR <b>P. Ruben E. Feldman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>	



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10280</u>	
BIRTH NO. <u>66 10280</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>66 10280</u>		1. NAME OF DECEASED (Type or Print) <u>BLUM (Blumfarb) Mayer</u>		2. DATE AND HOUR OF DEATH <u>10-7-66</u> <u>5:35 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hosp of Balt.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balt.</u> D. STREET ADDRESS (If rural, give location) <u>4333 Pimlico Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1/15/1907</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHOP (WOHLMUTH)</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HIRSH BLUMFARB</u>		14. MOTHER'S MAIDEN NAME <u>CHAI ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-03-5708</u>		17. INFORMANT <u>MR. AARON BLUM, 2908 GLEN AVENUE, APT C</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Cardio-Pulmonary Insufficiency</u> <u>Uremia</u> <u>Duodenal ulcer bleeding - Post-surgical</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>Sept 27, 1966</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>bleeding Duodenal ulcer</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-26</u> 19 <u>66</u> to <u>10-7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-7-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>CLARO W. P. O. RODA</u>		23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/9/66</u>		24C. NAME of CEMETERY or CREMATORY <u>RUDOMER VEREIN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1966</u>			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>SAL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</u>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10281</b>	
BIRTH NO. <b>66 10281</b>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CARLAN, MAX</b>		2. DATE AND HOUR OF DEATH <b>10/8/66</b> <b>7:50 P</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSPITAL OF BALTIMORE</b>		A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>LEVINDALE NURSING HOME</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUC.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <del>11/11/1911</del>	9. AGE (In years lost birthday) <del>55</del> <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>MANUFACTURER</del> <b>SELF-EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <del>MANUFACTURING</del> <b>ROOFER</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-32-9270</b>		17. INFORMANT <b>Levinale Nursing Home Record</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Septicemic shock</b>		CAUSE OF DEATH <b>Septicemic shock</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Renal shutdown</b>		<b>24 hrs</b>	
		(C) DUE TO <b>etiology - urinary tract infection &amp; urethral dilatation</b>		<b>40 hrs</b>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6 OCT. 66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Urethral stricture</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While-At <input type="checkbox"/> Not While <input type="checkbox"/> Work AT Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>8 Oct AM 1966</b> to <b>8 Oct PM 1966</b> , that (1) (we) last saw the deceased alive on <b>3 Oct. PM 1966</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael L. Levin</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>8 OCT. 66 PM</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL LEVIN</b>		23D. ADDRESS <b>Sinai Hospital of Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1966</b>		25B. NAME OF REGISTRAR <b>John E. Feltman</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>	

General History of the United States  
The first part of the book is devoted to a general history of the United States from the discovery of the continent to the present time. The second part is devoted to a general history of the United States from the discovery of the continent to the present time.

The third part of the book is devoted to a general history of the United States from the discovery of the continent to the present time. The fourth part is devoted to a general history of the United States from the discovery of the continent to the present time.

The fifth part of the book is devoted to a general history of the United States from the discovery of the continent to the present time.

The sixth part of the book is devoted to a general history of the United States from the discovery of the continent to the present time.

The seventh part of the book is devoted to a general history of the United States from the discovery of the continent to the present time.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">66 10282</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">66 10282</span>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">VERA TOKAR</span>				2. DATE AND HOUR OF DEATH <span style="float: right;">OCTOBER 9, 1966   9:30 A.M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 2em;">42</span> SINAI HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE <span style="float: right;">Maryland</span>		B. COUNTY <span style="float: right;">27-20</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Baltimore</span>			
				D. STREET ADDRESS (If rural, give location) <span style="float: right;">2713 Hanson Ave.</span>			
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="float: right;">Widow</span>	8. DATE OF BIRTH	9. AGE (In years last birthday) <span style="float: right;">81</span>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Home</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Russia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">USA</span>	
13. FATHER'S NAME <span style="float: right;">Jacob Shane</span>				14. MOTHER'S MAIDEN NAME <span style="float: right;">Sarah ?</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="float: right;">Mrs. Rose Goldsmith -- Same</span>		ADDRESS	
18. <span style="font-size: 1.5em;">420.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Arteriosclerosis, heart disease with coronary occlusion + pulmonary</span> (B) <span style="font-size: 1.2em;">Edema</span> (C) <span style="font-size: 1.2em;">Arteriosclerosis, general</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">1 hr.</span>  <span style="float: right;">35 yrs</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.5em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">Jan 9 1956</span> to <span style="float: right;">Oct. 9 1966</span> , that (I) ( <del>We</del> ) lost saw the deceased alive on <span style="float: right;">Oct. 9 1966</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Jonas Cohen</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">Oct. 10, 1966</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">DR. JONAS COHEN</span>				23D. ADDRESS <span style="float: right;">6702 Park Heights Ave.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/10/66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Beth Tfiloh Cong.</span>		24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <span style="float: right;">Sol Levinson</span>		25C. FUNERAL DIRECTOR <span style="float: right;">SOL LEVINSON &amp; BROS INC.</span>		ADDRESS <span style="float: right;">6010 Reist Rd.</span>	

Intermountain  
Horse and Cattle  
Ranch - General  
Store

Oct 10 1900

Oct 10 1900

Oct 10 1900

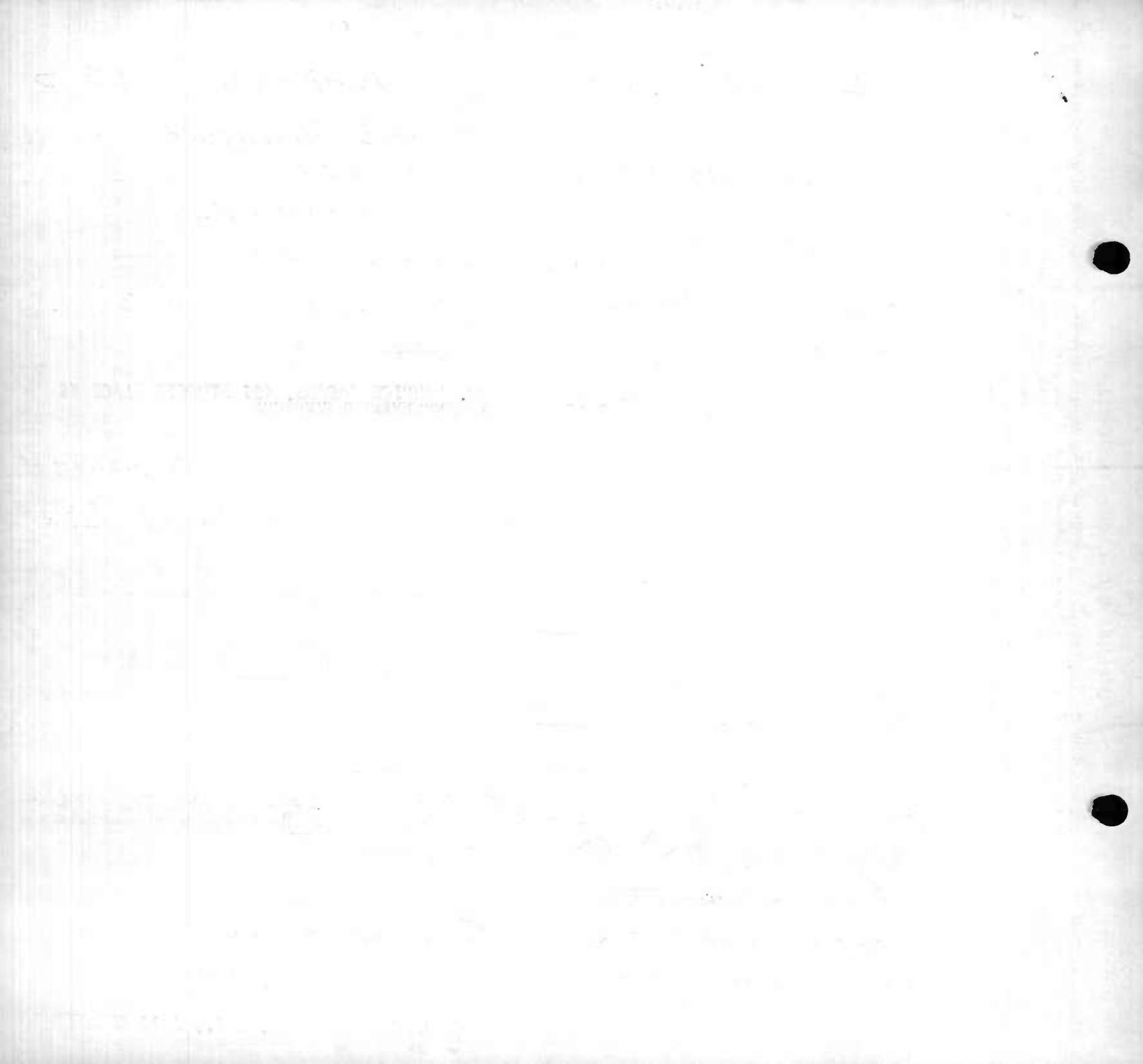
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Forrest

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10283</u>	
BIRTH NO. <u>66 10283</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LILLIAN JACOBS</u>		2. DATE AND HOUR OF DEATH <u>10-8-66</u> <u>2:00</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE Co.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>801 STURGIS PL.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-22-21</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months: <u>—</u> Days: <u>—</u> If Under 24 Hrs. Min. <u>—</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>HYMAN MILLER</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-3134</u>		17. INFORMANT <u>MR. MAURICE JACOBS</u> ADDRESS <u>801 STURGIS PLACE #8</u>	
18. <u>445 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>UREMIA</u> DUE TO (B) <u>MALIGNANT HYPERTENSION</u> DUE TO (C) <u>2 Yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>8-26</u> 19 <u>66</u> to <u>10-8</u> 19 <u>66</u> . that <u>(I)</u> (we) last saw the deceased alive on <u>10-8</u> 19 <u>66</u> and that it <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Alvin Schachter</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>ALVIN SCHACHTER</u>		23D. ADDRESS <u>M.O. SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/10/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Q. B. &amp; E. F. F. F.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10284	
BIRTH NO. 66 10284		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Nathan Levy</i>		2. DATE AND HOUR OF DEATH <i>October 8 / 66 7:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)		15-09	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i> B. COUNTY			
<i>3857 Forest Park One</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location)				<i>3857 Forest Park One</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>Married</i>	8. DATE OF BIRTH <i>Aug 14, 1882</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Retired</i>		<i>Salesman</i>		<i>Lithuania</i>	
13. FATHER'S NAME <i>Harry Levy</i>		14. MOTHER'S MAIDEN NAME <i>Mary?</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>402-09-1342</i>		17. INFORMANT <i>Mrs. Naomi Levy</i> ADDRESS <i>3857 Forest Park One</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <i>Arteriosclerotic C/Disease</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Diabetes Mellitus</i>		<i>5 yrs</i>	
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1962</i> to <i>10/9</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/9/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. S. Hallins</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Edward S. Hallins</i>		23D. ADDRESS <i>4300 Liberty Heights Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 10/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Mount Knoch</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>John S. Johnson</i>		25C. FUNERAL DIRECTOR <i>6010 West</i>		ADDRESS	

Constitution of the  
United States

1914

1914

1914

1914

66 10285

BALTIMORE CITY HEALTH DEPARTMENT

66 10285

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LORENZO JONES

2. DATE AND HOUR PRONOUNCED DEAD

October 9, 1966 6:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1523 N. Stricker Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

11-14-46

9. AGE (In years  
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Jones

14. MOTHER'S MAIDEN NAME

Mary A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-48-3322

17. INFORMANT

ADDRESS

Louis Jones Jr. 27 N. Kussuth Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Diabetic Coma  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-12-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

George Kelson 1348 N. Calhoun St.

OCT 12 1966

OCT 12 1966

OCT 12 1966

OCT 12 1966

OCT 12 1966



# VALLEY FORGE

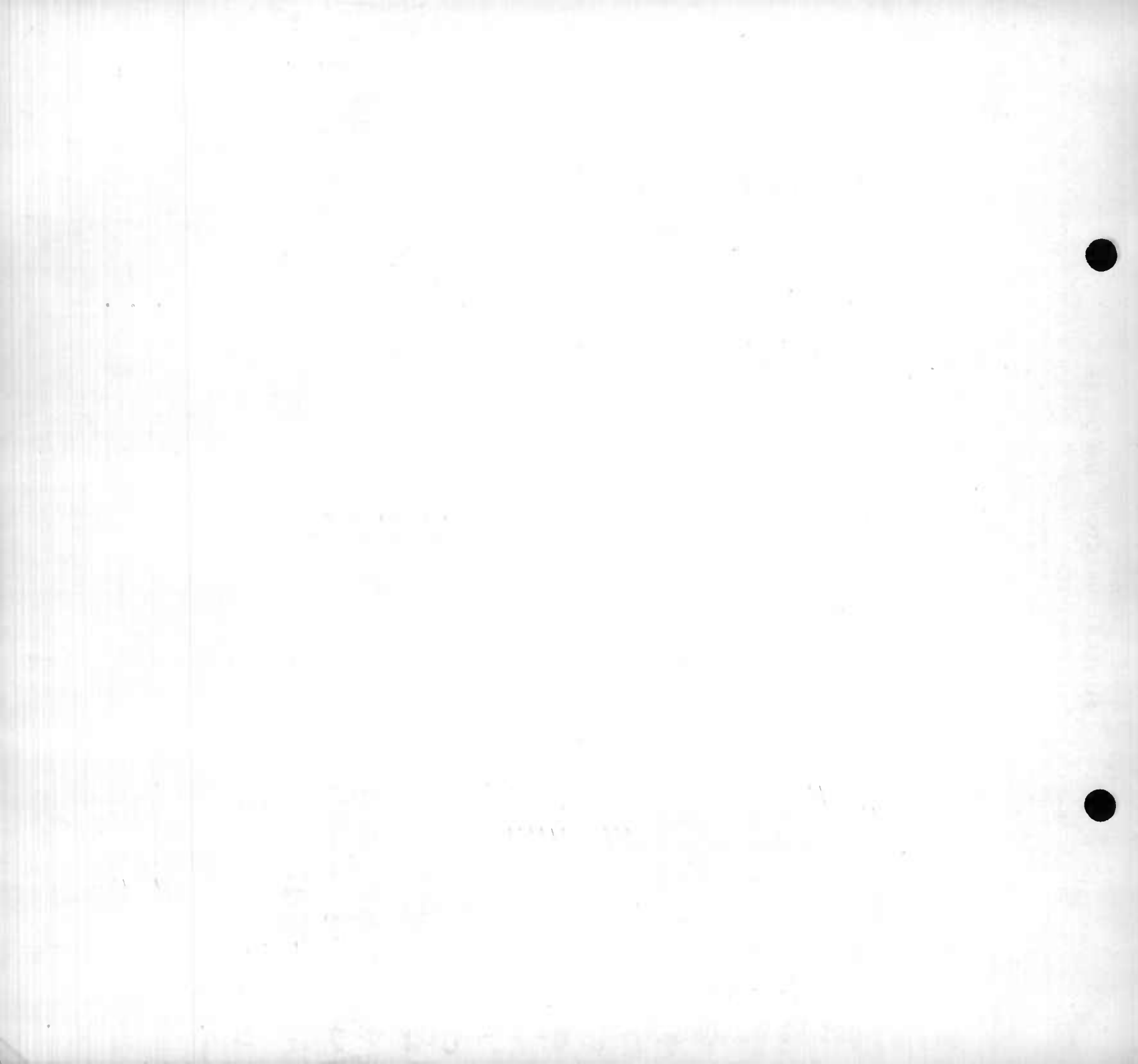
PAID CONTENT

NOV 11 1964

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 10286					Registered No. 66 10286				
BIRTH NO.					66 10286				
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>SARAH DENT</b>					<b>2. DATE AND HOUR OF DEATH</b> <b>10/11/66</b> <b>3:45 AM</b>				
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>33 JOHNS HOPKINS HOSPITAL</b>					<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-05</b> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>BALTIMORE 13</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>2029 SINCLAIR LANE</b>				
<b>5. SEX</b> <b>FEMALE</b>		<b>6. RACE</b> <b>NEGRO</b>		<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>WIDOW</b>		<b>8. DATE OF BIRTH</b> <b>1-5-85</b>		<b>9. AGE (In years last birthday)</b> <b>81</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10B. KIND OF BUSINESS OR INDUSTRY</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>MOSES JOYCE</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>CATHERINE Addison</b>				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>ADDRESS</b> <b>Regina Price 2709 Chelsea Terrace</b>				
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>422.11</b> <b>Probable Cerebrovascular accident</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>sev. days</b>				
<b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					<b>(A) DUE TO</b> <b>Arteriosclerotic cardiovascular disease.</b>				
					<b>(B) DUE TO</b> <b>? sepsis</b>				
					<b>(C) DUE TO</b> <b>50 years</b>				
					<b>sev days</b>				
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
<b>19A. DATE OF OPERATION</b> <b>2</b>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>			<b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)			<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from 10/10 19 66 to 10/11 19 66, that (I) (we) last saw the deceased alive on 10/11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>									
<b>23A. SIGNATURE</b> <b>San Shenk</b> M.D.								<b>23B. DATE SIGNED</b> <b>10/11/66</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Ian M. Shenk</b>					<b>23D. ADDRESS</b> <b>550 N. Broadway Balto. 5, MD.</b>				
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>10-10-66</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>New Catharal Cemetery</b>			<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 12 1966</b>			<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Falsma</b>			<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>George Kelson 1348 N. Calhoun St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10287	
BIRTH NO. 66 10287				CERTIFICATE OF DEATH	
M.E. CASE NO. (MARGJORIE)				2. DATE AND HOUR OF DEATH 10-11-66 10:35 A.M.	
1. NAME OF DECEASED (Type or Print) Margaret Griffin				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 21-02	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hosp.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230. D. STREET ADDRESS (If rural, give location) 910 Ryan St.	
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 6-20-1909		9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Virginia Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lee Dillon			14. MOTHER'S MAIDEN NAME Nannie Faust		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-18-4189	17. INFORMANT Mrs. Ethel Bullock - 405 Jonesboro Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Nutritional Embolism Pulmonary hemorrhage (B) DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH 6 mos 3 mos					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (at this hospital) attended the deceased from 10-2 19 66 to 10-21 19 66, that (we) last saw the deceased alive on 10-11 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bruther M.D.				23B. DATE SIGNED 10-11-66	
23C. PHYSICIAN'S NAME (Type) William J. Bruther M.D.				23D. ADDRESS South Baltimore General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/13/66		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) Balt., Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 12 1966			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
John J. Conway & Son, Inc.		901 Hollins St.		Balt., Md. - 21223	

1871

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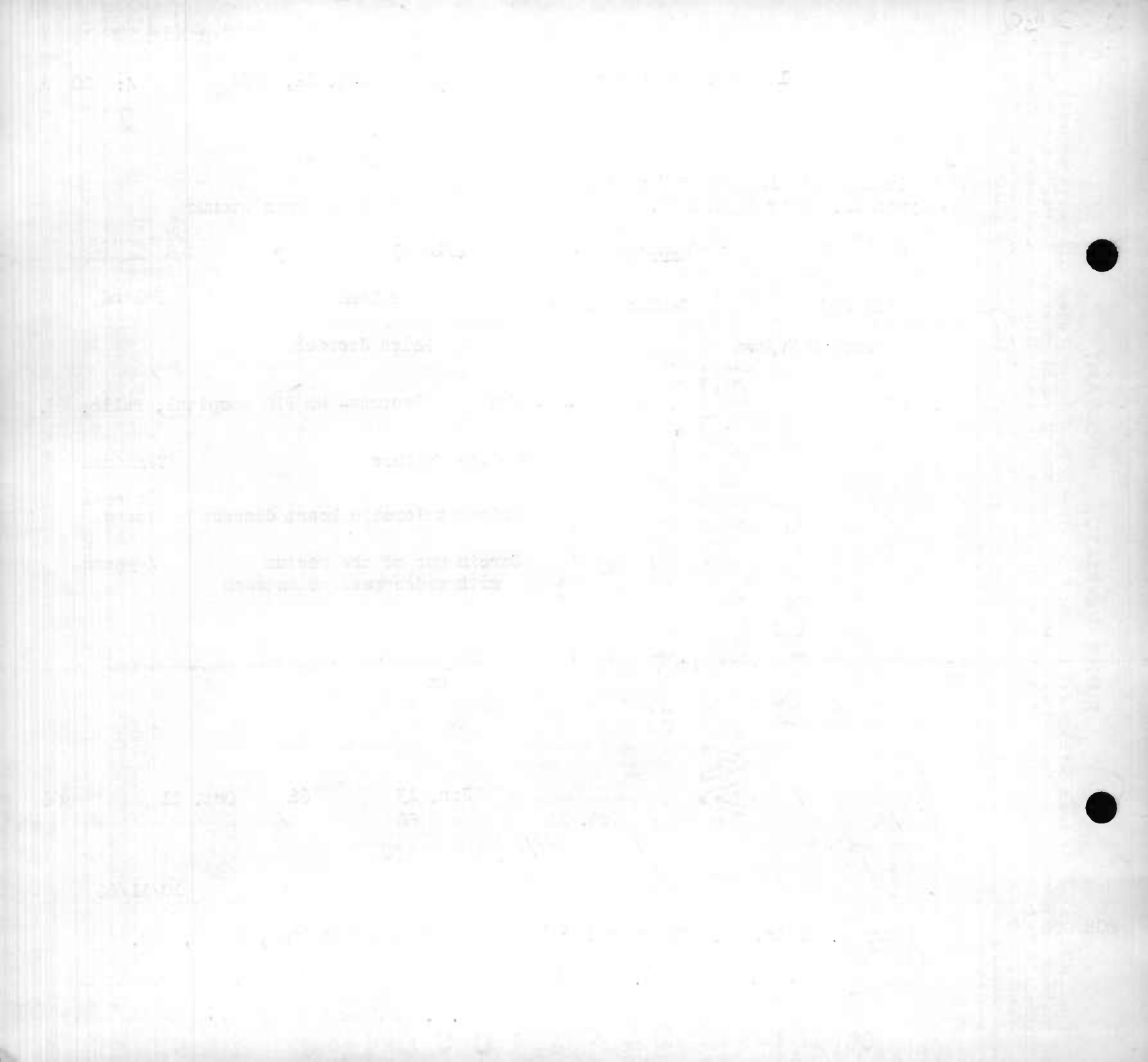
1871

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10288		CERTIFICATE OF DEATH		Registered No. 66 10288	
1. NAME OF DECEASED (Type or Print) <b>Walter Joseph Kujawa</b>						2. DATE AND HOUR OF DEATH <b>Oct. 11, 1966</b>   <b>4: 20 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st St.</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-01</b>			
5. SEX <b>M</b>						6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>						9. AGE (In years last birthday) <b>83</b>		10. DATE OF BIRTH <b>8/26/83</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>						12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>		13. FATHER'S NAME <b>Francis Kujawa</b>	
14. MOTHER'S MAIDEN NAME <b>Helen Jesnach</b>						15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-0607</b>	
17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>						18. CAUSE OF DEATH <b>Cardiac failure</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b>						19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcin oma of the rectum with widespread metastases</b>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 13</b> 19 <b>66</b> to <b>Oct. 11</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct. 11</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Henry W. White, Jr.</i>						23B. DATE SIGNED <b>10/11/66</b>		23C. PHYSICIAN'S NAME (Type) <b>Henry W. White, Jr. (SA Surgeon (R) M.D.)</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>						24B. DATE <b>10/14/66</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus</b>	
25A. DATE REC'D BY HEALTH DEPT.						25B. NAME OF REGISTRAR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>		25C. FUNERAL DIRECTOR <b>ADDRESS</b>	
24D. LOCATION (City, State) <b>Baltimore, Maryland</b>						24E. LOCATION (City, State) <b>Baltimore, Maryland</b>		24F. LOCATION (City, State) <b>Baltimore, Maryland</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. <b>66 10289</b>						
BIRTH NO. <b>66 10289</b>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <b>William Shenton</b>					2. DATE AND HOUR OF DEATH <b>10/9/66 6.10 P M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION <b>Should Convalesarium</b> (If not in hospital or institution, give street address or location)					A. STATE <b>Md.</b>						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. 27-06</b>						
					D. STREET ADDRESS (If rural, give location) <b>6105 Hamour Rd.</b>						
5. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED</b> (specify)		8. DATE OF BIRTH <b>9/26/81</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Davidson Chemical Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Wm. Geo. Washington</b>					14. MOTHER'S MAIDEN NAME <b>Harriet Meekens</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-070058A</b>		17. INFORMANT ADDRESS <b>Welda Penzel 6105 Hamour Rd.</b>							
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arteriosclerosis, generalized</b> <b>Pericarditis anemica</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>2 months</b> <b>2 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>August 18 1966</b> to <b>October 9 1966</b> , that (I) <del>we</del> <b>we</b> saw the deceased alive on <b>October 9 1966</b> and that in (my) <del>last</del> <b>last</b> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <b>(We)</b> <del>(did)</del> <b>(did not)</b> view the body after death.											
23A. SIGNATURE <b>E. J. Alessi</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>10/9/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>E. J. Alessi</b>					23D. ADDRESS <b>6217 Harford Rd</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge</b>		24D. LOCATION (City, town, or county) (State) <b>Md.</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>			25C. FUNERAL DIRECTOR <b>Helmut Hoffmann</b>			ADDRESS <b>3218 Hudson St</b>			

10/2/01

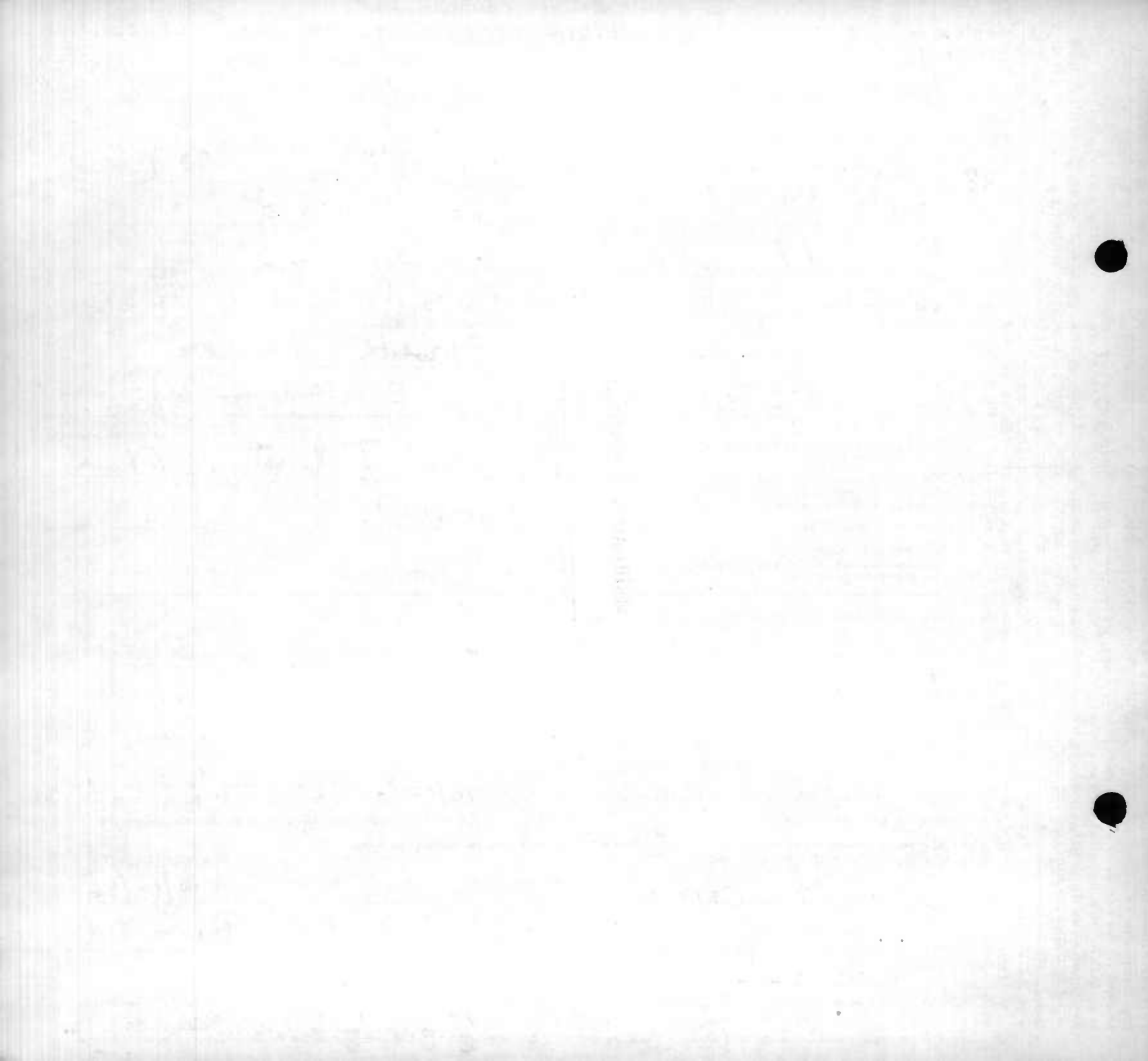
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Released By MEU on approval - Per Mr. Frankel.  
H-5510

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10290				CITY HEALTH DEPARTMENT		Registered No. 66 10290	
M.E. CASE NO. 66 10290				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Hammen Joseph</u>				2. DATE AND HOUR OF DEATH <u>10-10-66</u> <u>1</u> / <u>55</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY Hospital Balto. Md.</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>6802 HUDSON ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6/10/24</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Building (Electrical)</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md. USA</u>	
13. FATHER'S NAME <u>Joseph Hammen (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Auesser</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW II - Medic</u>				16. SOCIAL SECURITY NO. <u>215-1815319</u>		17. INFORMANT <u>Wife Elizabeth Hammen</u>	
18. I <u>4201</u> I <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH <u>Myocardial Infarction</u>		ADDRESS <u>6802 Hudson St. Balto.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>10/10</u> 19 <u>66</u> to <u>10/10</u> 19 <u>66</u> , that (1) (we) lost saw the deceased alive on <u>10/10</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>I.M. Sopher</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/10/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>I.M. Sopher</u>				23D. ADDRESS M.D. <u>University Hosp. Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-14-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>OCT 12 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Thelma A. Hoffmann</u>		ADDRESS <u>3218 Hudson St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10291		CERTIFICATE OF DEATH		Registered No. 66 10291		
1. NAME OF DECEASED (Type or Print) <b>Nellie P. Keller</b>				2. DATE AND HOUR OF DEATH <b>Oct. 9, 1966 2:30 A.M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1105 E. Fayette Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Cecil Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Conowingo Rural 57-00</b> D. STREET ADDRESS (If rural, give location)						
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>9/21/88</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Jerome Plank</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Butt</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-22-3408</b>		17. INFORMANT <b>Richard Keller</b>				ADDRESS <b>Conowingo, Md.</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b> (A) DUE TO  ANTECEDENT CAUSES (B) DUE TO  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> (C) DUE TO  INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>Several yrs</b>										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>01316131</del> ) attended the deceased from <b>July 25</b> 19 <b>66</b> to <b>Oct. 9</b> 19 <b>66</b> , that (I) ( <del>no</del> ) last saw the deceased alive on <b>Oct. 8</b> 19 <b>66</b> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.										
23A. SIGNATURE <b>E. Ellsworth Cook</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Oct. 9, 1966</b>		
23C. PHYSICIAN'S NAME (Type) <b>E. Ellsworth Cook</b>			23D. ADDRESS <b>2431 Maryland Ave</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hopewell Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Port Deposit Cecil Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>			25C. FUNERAL DIRECTOR <b>E. Ellsworth Cook</b>		ADDRESS <b>Rising Sun, Md.</b>			

Oct. 2, 1955

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Worcester

Worcester, Mass.

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66 10292

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10292

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Mildred Anderson

2. DATE AND HOUR PRONOUNCED DEAD

10/7/66 8:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 25-33

D. STREET ADDRESS (If rural, give location)

2318 Hollins Ferry Rd.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/8/33

9. AGE (In years  
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

New York City, N Y

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Hedrick Hargett

14. MOTHER'S MAIDEN NAME

Irene

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Birth Certificate

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Second and Third Degree Burns over  
majority of body surface

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED20A. AUTOPSY? (Yes or No)  
no20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2318 Hollins Ferry Rd. 25-33

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
about 10 7 66 8:00 a.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

conflagration in home

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/7/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/14/66

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 13 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS



# VALLEY FORD

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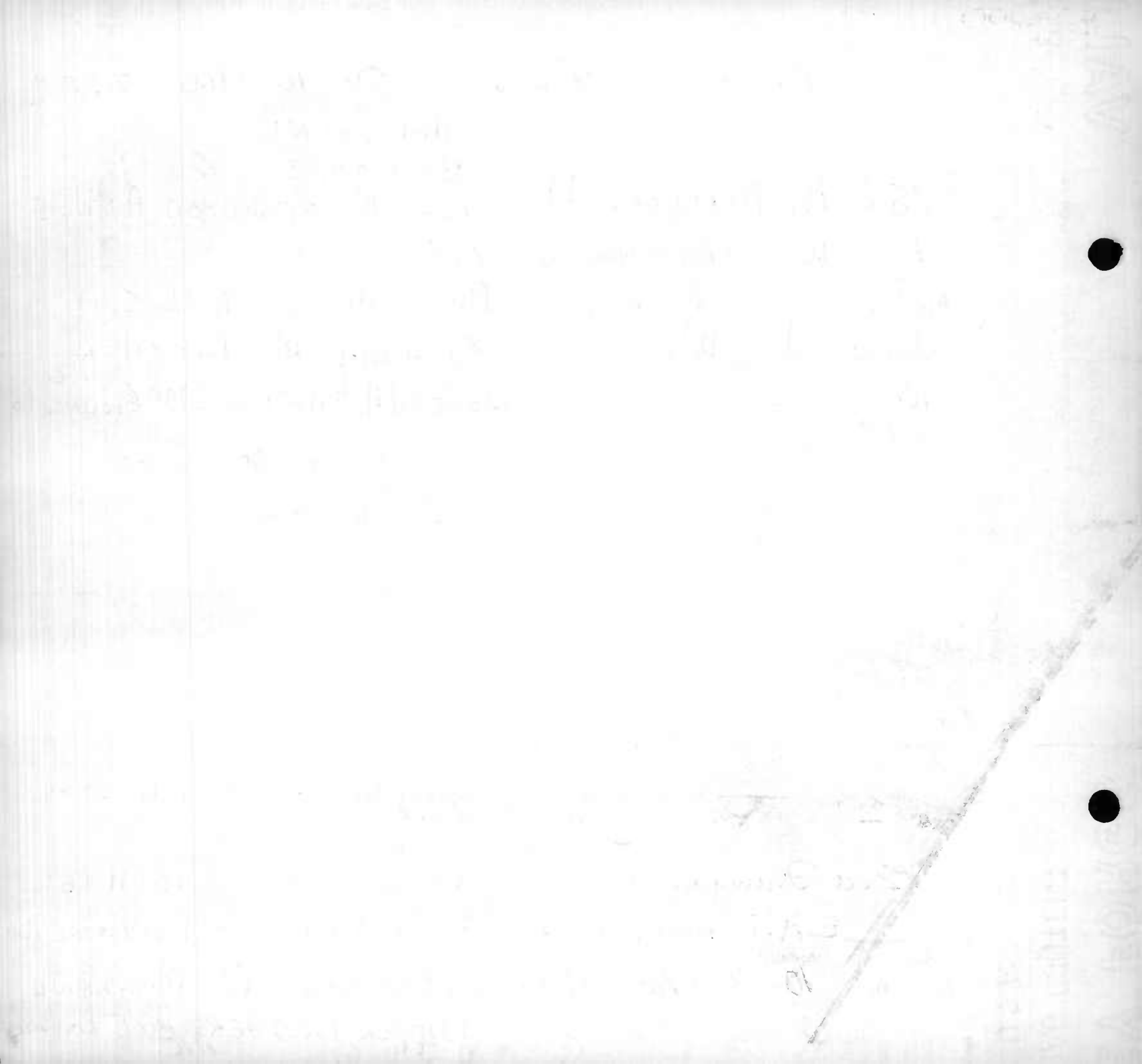
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10293	
BIRTH NO. 66 10293				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ANNA C. WEIS</b>			2. DATE AND HOUR OF DEATH <b>OCT 10 - 1966 7:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>152 N. KENWOOD AVE.</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>6-02</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BAKIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>152 N. KENWOOD AVENUE</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>9-15-1900</b>	9. AGE (In years lost birthday) <b>66</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPT.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>BAKTO. MARYLAND U. S. A.</b>	
13. FATHER'S NAME <b>JOHN J. WEIS</b>		14. MOTHER'S MAIDEN NAME <b>CECELIA M. FISCHER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-3559</b>		17. INFORMANT ADDRESS <b>JOSEPH A. KAPTAIN 5308 6000 Now Rd APT 6</b>	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>acute coronary occlusion</b>			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes Mellitus</b>			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 30 1961</b> to <b>OCT 10 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>OCT 10 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>E. A. FLANIGAN JR.</b>				23B. DATE SIGNED <b>10/11/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. A. FLANIGAN JR. M.D.</b>				23D. ADDRESS <b>3501 FAIT AVE BALTIMORE MD</b>	
24A. REMOVAL CREMATION, (Specify) <b>BURIAL</b>		24B. DATE <b>10-13-66</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEM</b>	
24D. LOCATION (City, town, or county) (State) <b>BEHAIK RD MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fajana</b>		25C. FUNERAL DIRECTOR ADDRESS <b>DIPPER BROTHERS 1800 E. Lombard INC.</b>			



F-636

BIRTH NO. 66 10294		BALTIMORE CITY HEALTH DEPARTMENT		66 10294	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print) LEROY <del>W</del> H. FREDERICK				2. DATE AND HOUR PRONOUNCED DEAD October 9, 1966 9:02 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-03 D. STREET ADDRESS (If rural, give location) 3304 Clifftmont Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH June 1, 1909	9. AGE (In years last birthday) 57	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber-Steam Fitter-Western Md. Dairy		10B. KIND OF BUSINESS OR INDUSTRY Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Frederick			14. MOTHER'S MAIDEN NAME Margaret Mallon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) yes WW 2 - Army 217-05-6262		16. SOCIAL SECURITY NO. 217-05-6262		17. INFORMANT ADDRESS Anna Denford Frederick, wife, above	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/10/66	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 10/13/66		23C. NAME OF CEMETERY or CREMATORY Baltimore National Cem	
24A. DATE REC'D BY HEALTH DEPT. OCT 13 1966		24B. NAME OF REGISTRAR R. B. E. F.		24C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	

WATERLOO

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10295</b>	
BIRTH NO. <b>66 10295</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARGARET SCHWARZ</b>		2. DATE AND HOUR OF DEATH <b>Oct. 10, 1966 6<sup>50</sup> A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>90 Gould Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write rural and give township) <b>3009 McElderry St Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3009 McElderry St Baltimore</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	B. DATE OF BIRTH <b>March 17, 1879</b>	9. AGE (In years last birthday) <b>87</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Adelsdorf, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>
13. FATHER'S NAME <b>George Moenius</b>			14. MOTHER'S MAIDEN NAME <b>Kunigunda Kratz</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>215-46-5250</b>		16. SOCIAL SECURITY NO. <b>215-46-5250</b>	17. INFORMANT ADDRESS <b>Herman P. Schwarz, son above</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized arthritis</b> <b>Large Decubitus Ulcer</b>			<b>?</b>		
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>Sept 14 1966</b> to <b>Oct 10 1966</b> , that (I) <del>(last)</del> last saw the deceased alive on <b>Oct 7 1966</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Louis F. Klimes</b>				23B. DATE SIGNED <b>Oct 10, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>LOUIS F. KLIMES</b>				23D. ADDRESS <b>2623 E. Monument St Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
				24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jarboe</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 2601 E. Madison St.</b>	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10296</b>	
BIRTH NO. <b>66 10296</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LEECH McCORMICK SHAYER</b>		2. DATE AND HOUR OF DEATH <b>10/9/66</b>		10:53 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Gould Convalesarium</b>		A. STATE <b>md.</b> B. COUNTY <b>Balto.</b>		CITY OR TOWN <b>Balto. Co</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
		<b>Kingsville</b>		<b>53-00</b>	
		<b>Mt. Vista Rd</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>6/16/92</b>	9. AGE (In years last birthday) <b>74</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Edgewood Chisel</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Am. USA</b>		13. FATHER'S NAME <b>JOSEPH SHAYER</b>		14. MOTHER'S MAIDEN NAME <b>NANNY HASH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-05-9966</b>		17. INFORMANT ADDRESS <b>Mrs Jennie A. Shaver Mt. Vista Road 21087</b>	
18. <b>422.1 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<b>Cerebral Thrombosis</b>		<b>1 hr. 53 min.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>General Arterioscl. CVD</b>		<b>14 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Emphysema</b>		<b>34 yrs -</b>	
<b>Provenial Asthma</b>					
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 8, 1935</b> to <b>Oct 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct 9, 1966</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>Clifford F. Hudson</b>				23B. DATE SIGNED <b>10/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>				23D. ADDRESS <b>FORK M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-15-66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Bridle Creek Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Bridle Creek Va.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>	25C. FUNERAL DIRECTOR ADDRESS (36) <b>Lossahn Funeral Home 7401 Blau Road</b>			

1954

1000 ft. above sea level

Kindred  
Altitude 1000

1000 ft. above sea level

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1000 ft. above sea level

1000 ft. above sea level  
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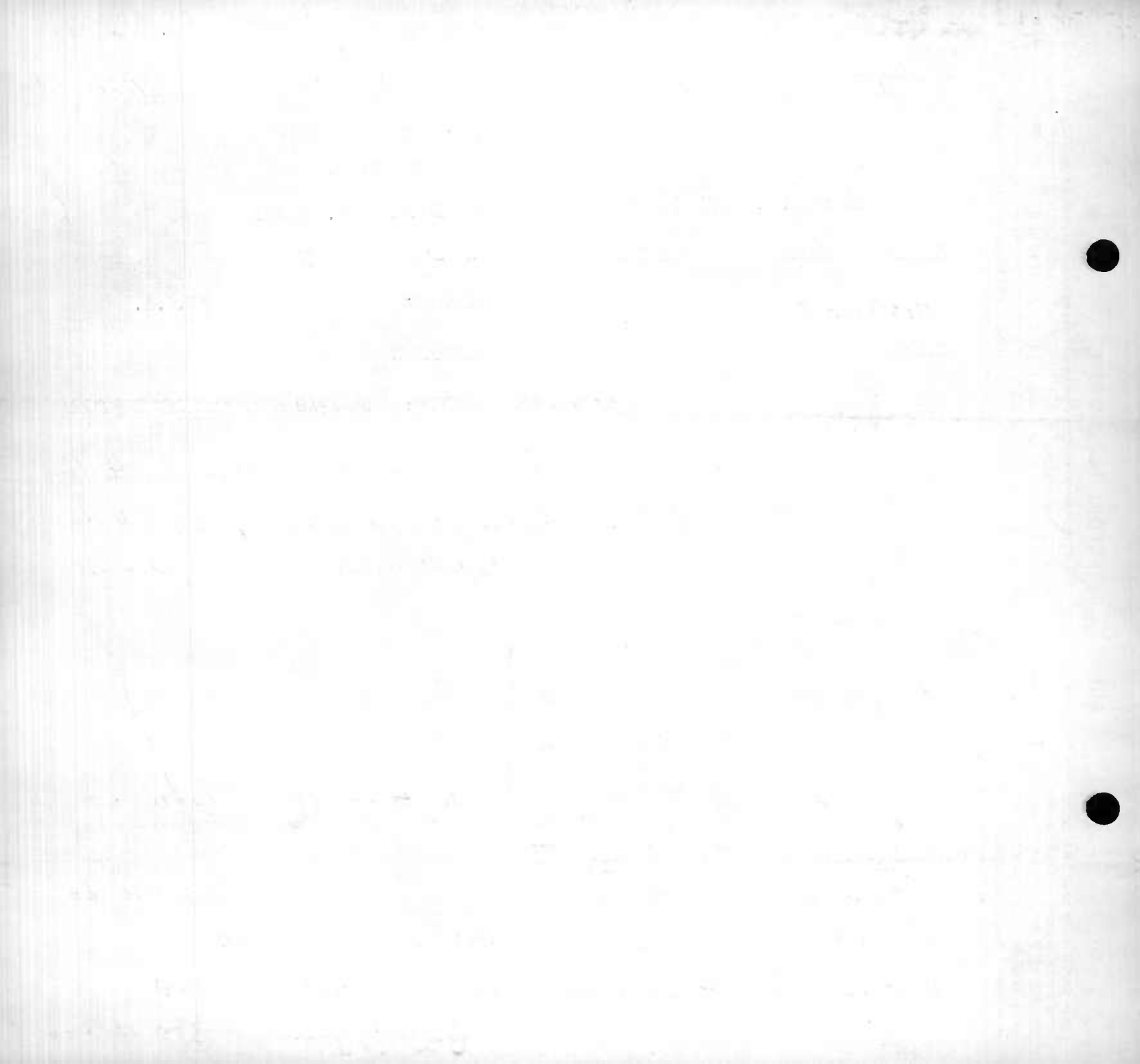
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10297		BALTIMORE CITY HEALTH DEPT.		Registered No. 66 10297	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ida Hockaday</i>		2. DATE AND HOUR OF DEATH <i>10-10-66 9:20 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE COUNTY</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>		D. STREET ADDRESS (If rural, give location) <i>409 HORSEY AVE. #21221</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED <i>MARRIED</i>	8. DATE OF BIRTH <i>9-23-12</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RESTURANT</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>GEORGE</i>		14. MOTHER'S MAIDEN NAME <i>KATHERINE</i>		17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 EASTERN AVENUE #21224</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-44-6185</i>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>330 X I</i> <i>Intra cerebral hemorrhage</i> <i>Rupture into subarachnoid space</i> <i>Hypertension</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>10-10-66</i> to <i>10-10-66</i> , that (we) last saw the deceased alive on <i>10-10-66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.					
23A. SIGNATURE <i>Richard Y. Bishop</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10-10-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. RICHARD BISHOP</i>		23D. ADDRESS <i>4940 EASTERN AVENUE #21224</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/14/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>MEADOW RIDGE</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 13 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Gracelynn</i>		ADDRESS <i>300 more</i>	



S-353 66 10298

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 66 10298

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Sutinen, Renee

2. DATE AND HOUR OF DEATH

10/10/66 1:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hosp  
4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

404 S. Dean St. #21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-11-11

9. AGE (In years  
last birthday)

55

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

FORREST VIA

14. MOTHER'S MAIDEN NAME

ANNIE DOOMS

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

212-14-175

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue-21224

18. 420.1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Myocardial Infarction ~1 wk

(B) DUE TO

Pulmonary Emboli ~1 wk

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 10/5 1966 to 10/10 1966  
that (1) (we) last saw the deceased alive on 10/10 1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.A. Sullivan

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

10/10/66

23C. PHYSICIAN'S  
NAME (Type)

Mary Ann Sullivan

M.D.

23D. ADDRESS

BCH Baltimore, Maryland  
4940 Eastern Avenue24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL 10/13/66

BALTO. NATL.

BALTO.

MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OCT 13 1966

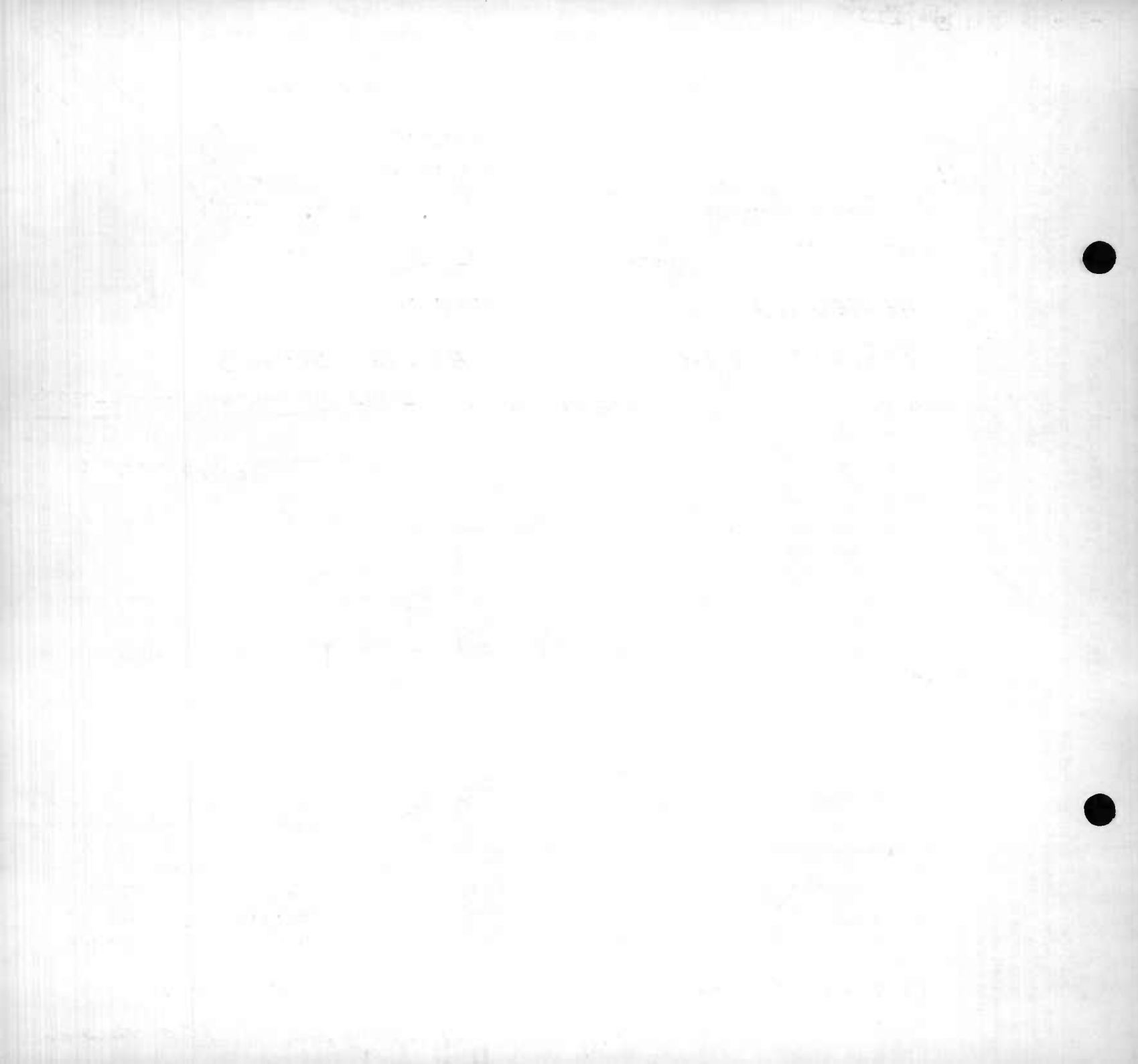
Robert E. Taylor

Connelly Son

300 more

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10299	
BIRTH NO. 66 10299		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BENJAMIN L. VAUGHN</b>		2. DATE AND HOUR OF DEATH <b>10/9/66 8.10 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTO. CITY HOSP.</b>		A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b> <b>Balto Co.</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ESSEX 53-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>518 RIVERSIDE RD.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5/9/1899</b>	9. AGE (In years lost birthday) <b>67</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>	
13. FATHER'S NAME <b>JOHN VAUGHN</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE REYNOLDS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-4105</b>		17. INFORMANT <b>JOHN VAUGHN</b> ADDRESS <b>518 RIVERSIDE</b>	
18. <b>422.1 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>CEREBRAL THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS.</b>	
ANTECEDENT CAUSES		(B) <b>ARTERIO-SCLEROTIC</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>CARDIO-VASCULAR DISEASE</b>		<b>14 YRS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JAN. 15 1951</b> to <b>OCT 9 1966</b> , that (I) (we) last saw the deceased alive on <b>SEPT 6 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph Mileli</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>OCT. 11, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH MILELI</b>		23D. ADDRESS <b>108 S. TAYLOR AVE, ESSEX, MD 21221</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/12/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NATL.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 13 1966</b>			
25B. NAME OF RECEPTOR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Cornelby Sons</b> ADDRESS <b>300 mma</b>			



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66 10300 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>		66 10300 Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
RADFORD E. SMITH			October 12, 1966 8:25 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home Hospital (DOA)			A. STATE Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 36 N. Patterson Park Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 15, 1916	9. AGE (In years last birthday) 49	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Armhein Bakery		11. BIRTHPLACE (State or foreign country) Paw Paw W.Va.	
13. FATHER'S NAME Jessie A. Smith			14. MOTHER'S MAIDEN NAME Gertrude Santeymeyer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. 232-26-7430		17. INFORMANT ADDRESS Mrs. June P. Smith, 506 N. Linwood Ave.	
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
(A) Hypertensive and arteriosclerotic cardiovascular disease (B) DUE TO (C)					
INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		Oct. 15/66		Mt. Nebo Pres. Cem.	
				23D. LOCATION (City, town, or county) (State) Paw Paw, West Va.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
OCT 13 1966		Robert E. Farber, M.D.		Philip Newington	
				ADDRESS 2024 Orleans St. 31	

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MAN CONSENT

Oct. 18, 1910

Received

Notarized at

Thomas A. Smith

Witnessed by

John A. Smith

Witnessed by John A. Smith, Notary Public, State of New York.

Notarized at

Oct. 18, 1910

Notarized at

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10301		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10301	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print) Robert Evans			2. DATE AND HOUR OF DEATH		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			10/12/66 8:25 A.M.		
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
38 University Hospital				A. STATE Maryland (Balt. city)	
				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore #17/6-01	
				D. STREET ADDRESS (If rural, give location)	
				1102 W. Mosher St	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Negro	separated	5/20/30	36	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				South Carolina	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Oliver Evans			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
unknown			unknown		hospital records
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) esophageal varices		unknown
ANTECEDENT CAUSES			(B) Lannec's cirrhosis		several years
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 none				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 9/22/66 to 10/12/66, that (2) (we) last saw the deceased alive on 10/12/66 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Susan L. Howard				10/12/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Susan L. Howard		University Hosp. Baltimore 1 Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/16/66		Harmony	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 13 1966		Robert E. Taylor		Charles Rice	
				ADDRESS	
				66 W. Bare St	

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10302

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>Marion R. Keck</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>10/11/66 2:40 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>625 S. Beechfield Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>625 S. Beechfield Ave.</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-15-1896</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NEW AMSTERDAM CASUALTY</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
13. FATHER'S NAME <b>MILO T. KECK</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE REARDON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>212-07-0357</b>	17. INFORMANT <b>MRS. ANNE M. KECK, 625 S. BEECHFIELD AVENUE</b>

MEDICAL CERTIFICATION	18. CAUSE OF DEATH <b>148X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of pharynx</b> DUE TO  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
	19A. DATE OF OPERATION <b>10-14-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>	
	20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) <b>10-11-66 2:40</b>	
	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
	22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
	ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
	23A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>10-14-66</b>	
	23C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		23D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>		24B. NAME OF REGISTRAR <b>R. E. Fairbank</b>		
24C. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>		24D. ADDRESS		

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10303				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10303	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				AUDREY A. LEHMANN		OCTOBER 10, 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 1801 LETITIA AVENUE				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				1801 LETITIA AVENUE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
FEMALE		WHITE		MARRIED		7-12-1924	
						9. AGE (In years last birthday) 42	
						If Under 1 Yr. Months Oys. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE						MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
J. LEO McCLOSKEY				MAYME A. CLARK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				217-14-2750		MR. CARL H. LEHMANN, 1801 <del>LEHMANN</del> LETITIA AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
170X I				(A) DUE TO			
ANTECEDENT CAUSES				Carcinomatosis. 11-15-65			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				Carcinoma, right breast. 8-16-63			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8/16/63		Carcinoma right breast		no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) <del>(this hospital)</del> attended the deceased from 7-15-63 to 10-10-1966, that (I) <del>(we)</del> last saw the deceased alive on 9-27-1966 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.							
22A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		22B. DATE SIGNED	
George H. Yeager						10-11-66	
22C. PHYSICIAN'S NAME (Type)				22D. ADDRESS			
GEORGE YEAGER				UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10-14-66		NEW CATHEDRAL CEMETERY		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 13 1966		Robert E. Taylor		HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. 66 10304
BIRTH NO. 66 10304						
M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH				
GEHRINGER OLIVE LOUISE		OCTOBER 10 1966		3:00 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION  ST AGNES HOSPITAL		A. STATE MD B. COUNTY				
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
		D. STREET ADDRESS (If rural, give location) 6612 ALTAMONT AVE. #28				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-27-02	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE DePRIEST			14. MOTHER'S MAIDEN NAME CAROLINE BROWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-5039		17. INFORMANT MR. W. MYLES DAMERON, 34 SHADY NOOK ST AGNES HOSPITAL CATON & WILKENS AV		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>Malignant nephrosclerosis with renal failure and uremia.</i>			INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from SEPT 29 19 66 to OCT 10 19 66, that (X) (we) last saw the deceased alive on OCT 10 19 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (XX) (did) (XXXX) view the body after death.						
23A. SIGNATURE <i>Dr. Marin</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/10/66
23C. PHYSICIAN'S NAME (Type) DR. MARIN		23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-14-66		24C. NAME OF CEMETERY or CREMATORY LOUEN PARK CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR OCT 13 1966		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229		

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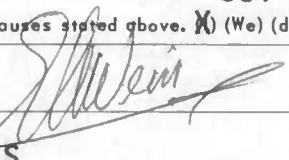
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

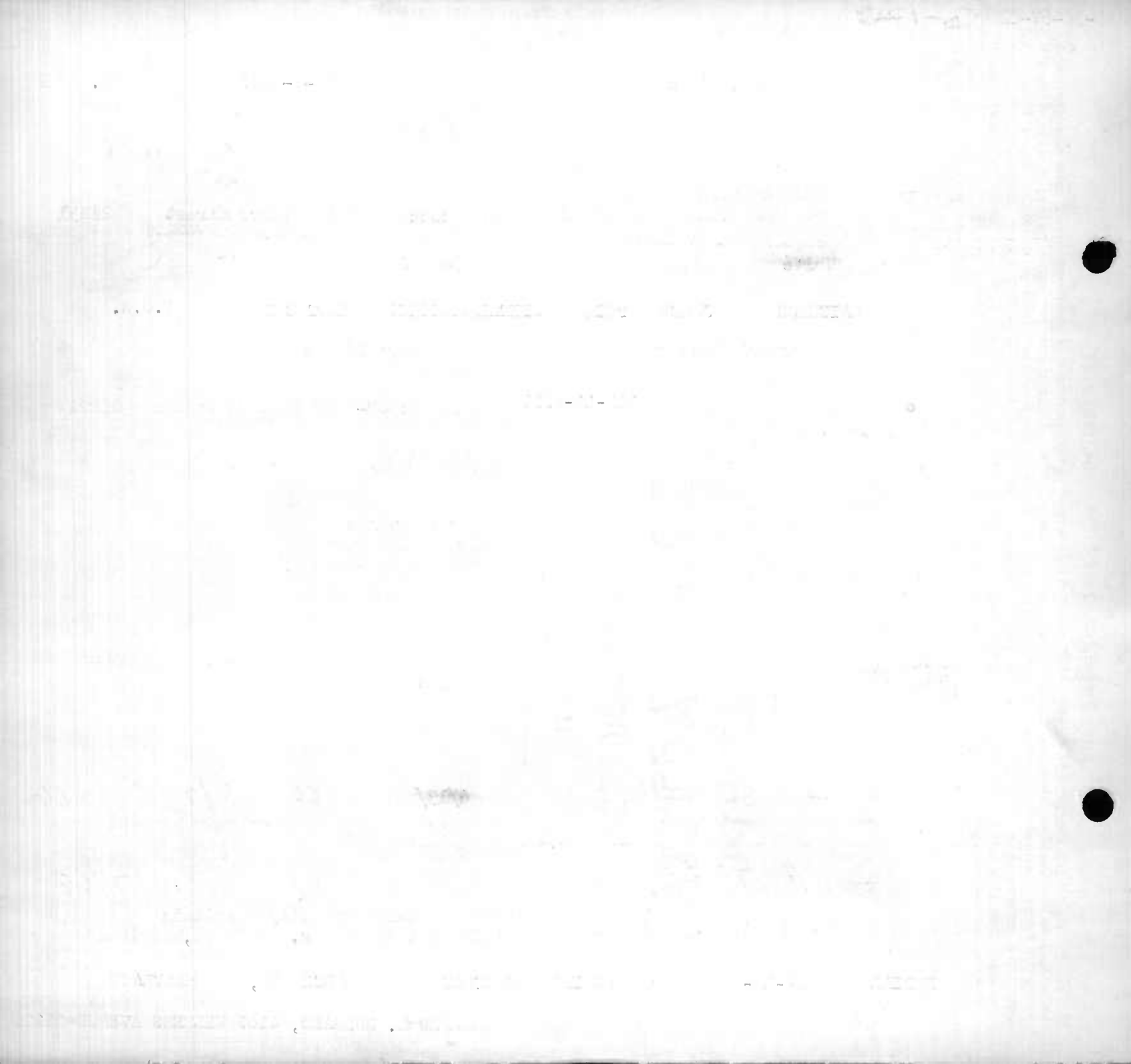
BIRTH NO.		66 10305		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10305	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GINGELL SARAH A</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 7 1966 2:40P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST AGNES HOSPITAL CATON AND WILKENS AVE.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>4140 WILKENS AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>12-15-78</b>	9. AGE (In years last birthday) <b>87</b>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>THOMAS GREEN</b>				14. MOTHER'S MAIDEN NAME <b>MARY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>214 24 0556</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Congestion</b> <b>ASCVD</b>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Alkaline, incriminated, hemorrhagic Gastritis</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPT 21 1966</b> to <b>OCT 7 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCT 7 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-7-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. H. WEISS</b>				23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL-CATON AND WILKENS AVENUES</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-10-66</b>		24C. NAME of CEMETERY or CREMATORY <b>LOUDON PARK CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10308		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10308	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Rose Gibbs		10-7-1966		2. 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		B. COUNTY Baltimore			
31		C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1908 1/2 East Baltimore Street 21231			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-2-1924	9. AGE (In years last birthday) 42	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS
		11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Durrard Flannery		14. MOTHER'S MAIDEN NAME Cora Little			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-9537		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Alcoholic cirrhosis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 More		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from 6/13/1966 to 10/7/1966, that (I) (we) last saw the deceased alive on 10/7/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (attend) view the body after death.					
23A. SIGNATURE Phillip L. Hall		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/7/66	
23C. PHYSICIAN'S NAME (Type) PHILLIP L. HALL		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-10-66		24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 13 1966		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE=21229	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 10307	
BIRTH NO. 66 10307		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mildred C. Collins			2. DATE AND HOUR OF DEATH October 9, 1966 8:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 4617 Kavon Ave			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-02 D. STREET ADDRESS (If rural, give location) 4617 Kavon Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 6, 1903	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John H. Egging		
14. MOTHER'S MAIDEN NAME Minna C. Kurtz			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-03-6428			17. INFORMANT ADDRESS John K. Lucky 1032 Lakemont Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) I 416X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH (A) DUE TO Congestive Heart Failure (B) DUE TO Rheumatic Heart Disease (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 30+ years.			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Metastatic Breast Carcinoma 2 mos.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from August 1962 to October 9, 1966, that (I) (we) last saw the deceased alive on October 8, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Albert B. Bradley 23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley		23D. ADDRESS 4900 BELair Road		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 10/12/66		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 13 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66-2186566 10308					CERTIFICATE OF DEATH		Registered No. 66 10308		
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>MELTON, BABY BOY (A)</b>					2. DATE AND HOUR OF DEATH <b>10-11-66 1:05 A. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ST. AGNES HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>WILKENS &amp; CATON AVES.</b> <b>BALTO., MD. 21229</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21225</b> D. STREET ADDRESS (If rural, give location) <b>1002 BRISTOL PLACE</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>10-9-66</b>	9. AGE (In years last birthday) <b>1 1/2 DAYS</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>YES</b>
13. FATHER'S NAME <b>WILLIAM E.</b>					14. MOTHER'S MAIDEN NAME <b>CAROLYN (TOMLINSON)</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>ST. AGNES RECORDS</b> ADDRESS <b>WILKENS &amp; CATON AVES</b> <b>BALTO., MD. 21229</b>		
18. <b>773.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hyaline membrane disease</b> <b>Prematurity</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT. 9, 1966</b> to <b>OCT. 11, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCTOBER 11, 1966</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>HAROLD BRENNER, MD.</b>					23B. DATE SIGNED <b>10.11.66.</b>			23C. PHYSICIAN'S NAME (Type) <b>HAROLD BRENNER, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10/11/66</b>			24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Ritchie H'way Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>			25B. NAME OF REGISTRAR <b>McGully</b>			25C. FUNERAL DIRECTOR <b>McGully</b>			ADDRESS <b>237 Patapsco Ave.</b>

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U.S. DEPARTMENT OF  
STATE  
WASHINGTON, D.C.

TO : DIRECTOR, FBI  
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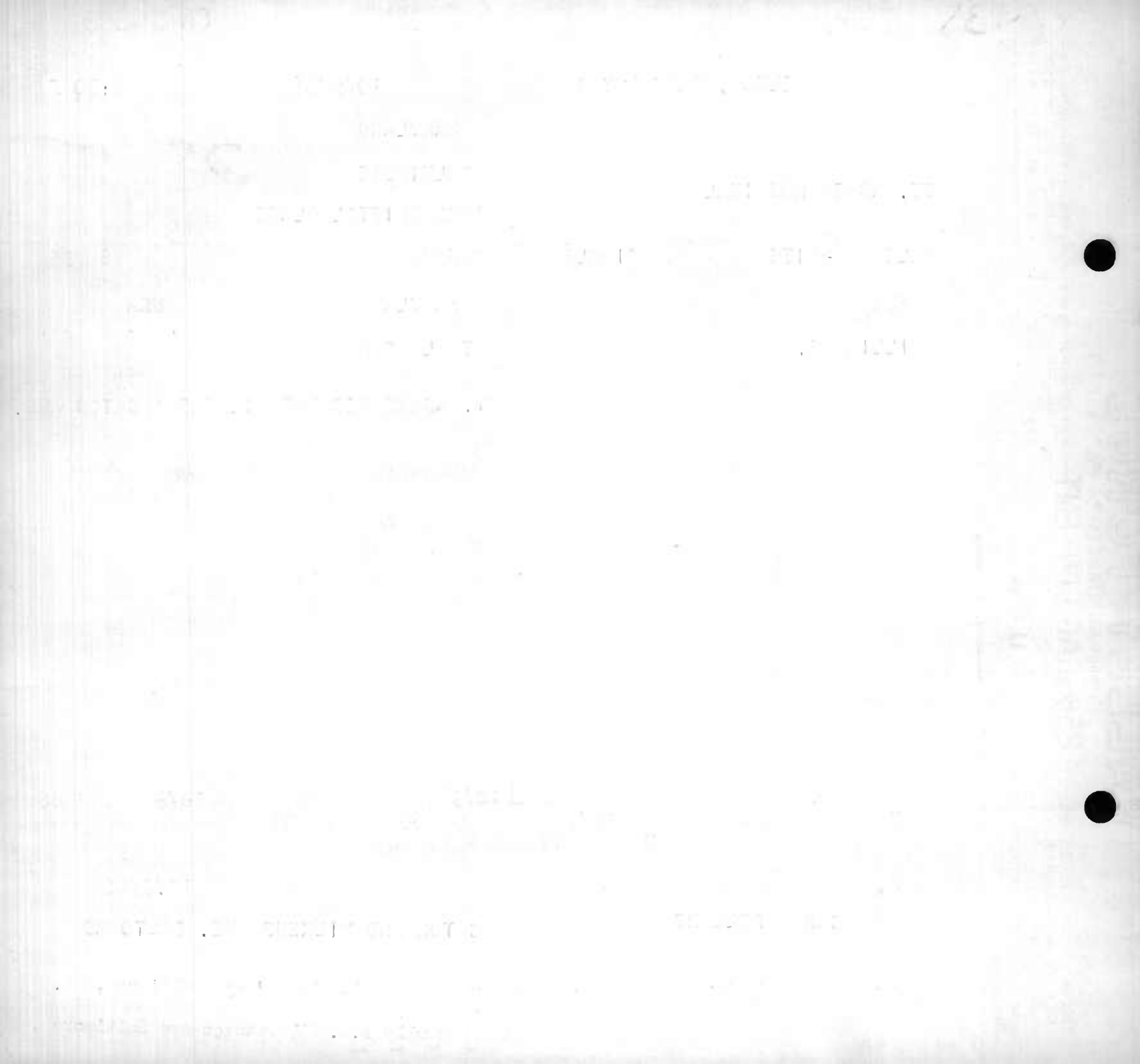
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U.S. DEPARTMENT OF  
STATE  
WASHINGTON, D.C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10309</b>	
BIRTH NO. <b>66-218666 10309</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MELTON, BABY BOY B</b>		2. DATE AND HOUR OF DEATH <b>10/9/66 8:30 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1002 BRISTOL PLACE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>10/9/66</b>	9. AGE (In years last birthday) <b>8 36</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM E.</b>			14. MOTHER'S MAIDEN NAME <b>TOMLINSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS WILKENS &amp; CATON AVE.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Prematurity</b> INTERVAL BETWEEN ONSET AND DEATH <b>since birth (8 hrs.)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Respiratory distress Syndrome</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>10/9 19 66</b> to <b>10/9 19 66</b> , that (X) (we) last saw the deceased alive on <b>10/9 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cora P. Arellano</b>				23B. DATE SIGNED <b>10/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CORA ARELLANO</b>				23D. ADDRESS <b>CATON AND WILKENS AVE. BALTO MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Ritchie H'way Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McGully F.H. 237 Patasco Ave Baltimore,</b>			

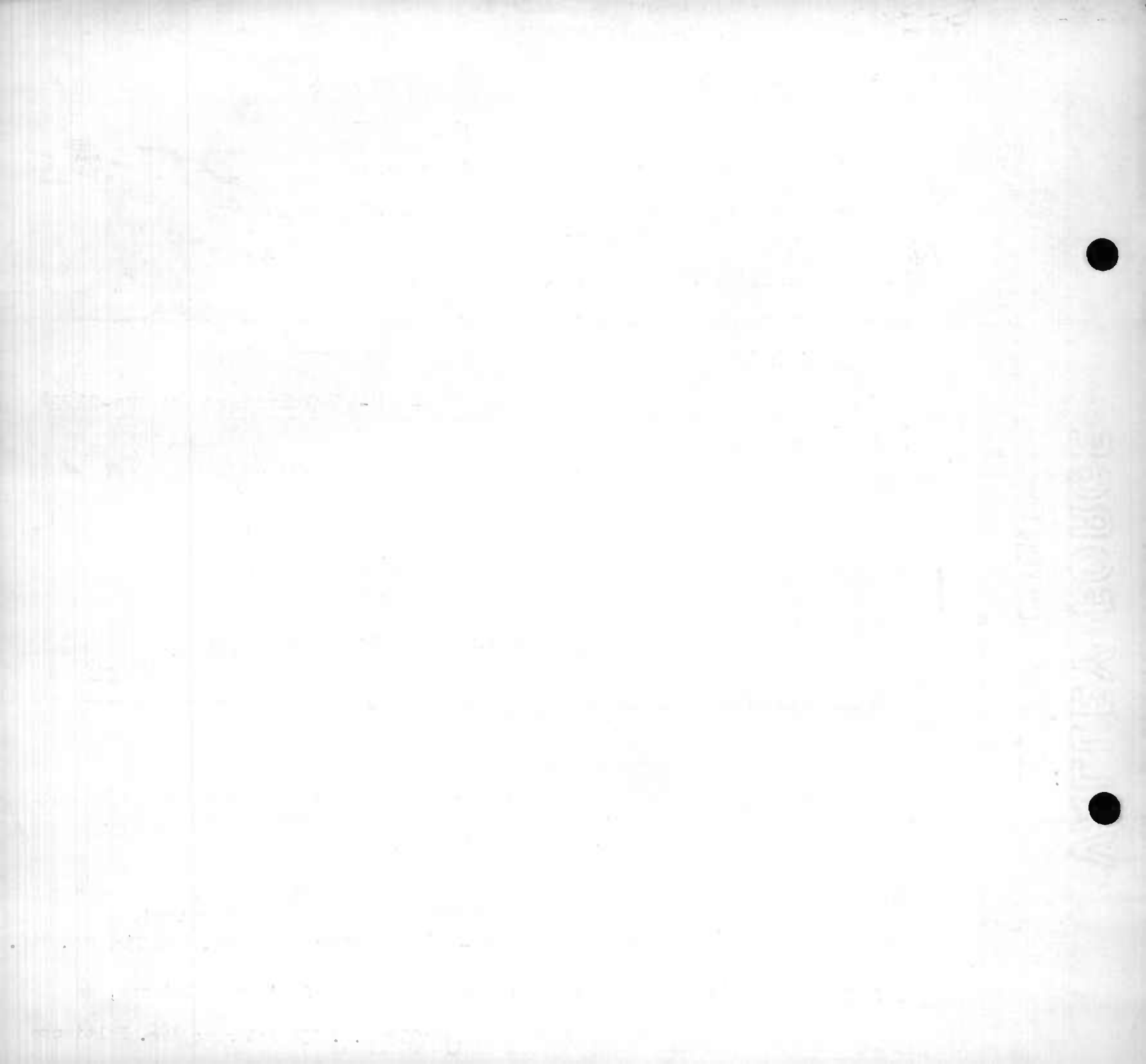




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10310</u>	
BIRTH NO. <u>5-362 66 10310</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>STRAUCH, REINHOLD</u>		2. DATE AND HOUR OF DEATH <u>10-9-66</u> <u>1:4:10 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 BALTIMORE CITY HOSPITALS EASTERN AVE. BALTIMORE, MD.</u>		A. STATE <u>MD.</u> B. COUNTY <u>-</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
		D. STREET ADDRESS (If rural, give location) <u>3611 S. MARGARET ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>9-28-22</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Reinhold</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>RECORDS-BCH-4940 Eastern Avenue-21224</u>	
18. <u>252XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Subarachnoid hemorrhage</u> DUE TO (B) <u>Hydrocephalus</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 mths</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Fever of Unknown origin - 12% Rectal abscess.</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/27/1966</u> to <u>10-9-1966</u> , that (I) (we) last saw the deceased alive on <u>10-9-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard Maffezzoli</u>				23B. DATE SIGNED <u>10-9-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>RICHARD MAFFEZZOLI</u>				23D. ADDRESS <u>#21224 BCH-4940 Eastern Avenue, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10/13/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pulaski H'way Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Falarin</u>	
25C. FUNERAL DIRECTOR <u>McGully F.H.</u>		25D. ADDRESS <u>237 Patapsco Ave. Baltimore</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10311</b>	
BIRTH NO. <b>66 10311</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ZARAFONETIS, MARY</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 11, 1966 6:55A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ST. AGNES HOSPITAL</b> (If not in hospital or institution, give street address or location) <b>WILKENS &amp; CATON AVES. BALTO., MD. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto. Co.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>40</b> <b>WILKENS &amp; CATON AVES. BALTO., MD. 21229</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO., XXXX 21234</b> 53-00	
				D. STREET ADDRESS (If rural, give location) <b>3500 HISS AVE. XXXX</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>6-7-06</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11. BIRTHPLACE (State or foreign country) <b>SAVANNAH, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>YES USA</b>
13. FATHER'S NAME <b>GEORGE</b>			14. MOTHER'S MAIDEN NAME <b>DEMITRA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>WILKENS &amp; CATON AVES ST. AGNES RECORDS - BALTO., MD 21229</b>					
18. <b>157 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Adeno carcinoma of Pancreas</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPT. 24, 1966</b> to <b>OCT. 11, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCT. 11, 1966</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Romualdo P. Dator, M.D.</b>				23B. DATE SIGNED <b>Oct. 11, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROMUALDO DATOR, M D</b> <b>FRANK XXXX DATOR XXXX</b>				23D. ADDRESS <b>WILKENS &amp; CATON AVES. BALTO., MD. 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/14/66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md. 21214</b>	

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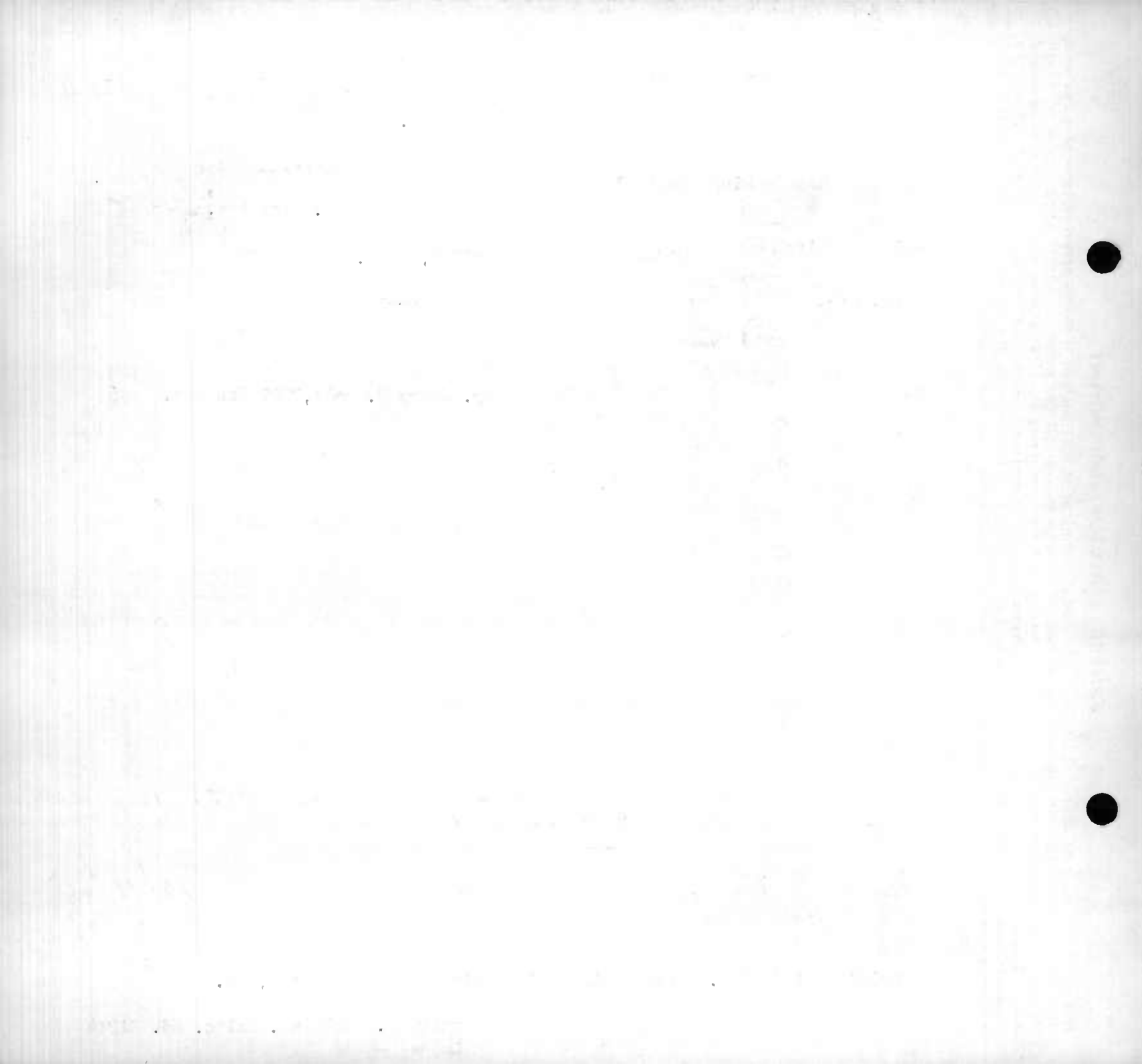
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">66 10312</span>	
BIRTH NO. <span style="font-size: 1.5em;">66 10312</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Eva May Wolf</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 11, 1966 12:20 A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">33</span> <span style="font-size: 1.2em;">Johns Hopkins Hospital</span> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore #24</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">439 N. East Ave.</span>	
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widow</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">April 9, 1894.</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">72</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">David Mumma</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Susan Crue</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Henry D. Wolf, 3707 Ina Ave. #6</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">422.11-002.1</span>		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Arteriosclerotic C V Disease</span> DUE TO <span style="font-size: 1.2em;">decompensation</span> (B) <span style="font-size: 1.2em;">Generalized Arteriosclerosis</span> DUE TO <span style="font-size: 1.2em;">Unknown</span> (C)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 week.</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<span style="font-size: 1.2em;">1) Pulmonary Tuberculosis</span> <span style="font-size: 1.2em;">2) Epilepsy</span>		<span style="font-size: 1.2em;">3 months</span> <span style="font-size: 1.2em;">10 years.</span>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Feb 3</span> 19 <span style="font-size: 1.2em;">53</span> to <span style="font-size: 1.2em;">Oct. 10</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">9/28/66</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Henry J. Houska</span>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">10/11/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Henry J. Houska</span>		M.D. <span style="font-size: 1.2em;">333 S. East Ave Balto Md 21224</span>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/14/66.</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Fork Methodist Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Fork, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 13 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. E. Feltner</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck Inc. Balto. Md. 21214</span>		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10313				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 10313	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>EAGAN, Hugh C.</b>				2. DATE AND HOUR OF DEATH <b>10/11/66 12:45 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42, Sinai Hosp</b>				A. STATE <b>MD.</b>		B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 53-00</b>	
D. STREET ADDRESS (If rural, give location) <b>7821 DANIELS AVE</b>				5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>7/5/91</b>				9. AGE (In years last birthday) <b>75</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fleet Supt.</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>National Brewery</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Hugh H. Eagan</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Frederick</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-09-4147</b>		17. INFORMANT ADDRESS <b>Mrs. Mildred Skelton, 8526 Oakleigh Rd. #34</b>			
18. <b>594 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Gouty Nephritis</b>				CAUSE OF DEATH (A) DUE TO <b>Gout</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Anemia (unk. Aet.)</b>				(B) DUE TO				(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/9/66</b> 19 to <b>10/11/66</b> 19, that (I) (we) last saw the deceased alive on <b>10/11/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <b>[Signature]</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED <b>10/11/66</b>					
23C. PHYSICIAN'S NAME (Type) <b>Anthony Bottona</b> M.D.				23D. ADDRESS <b>Sinai Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10/14/66.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>			

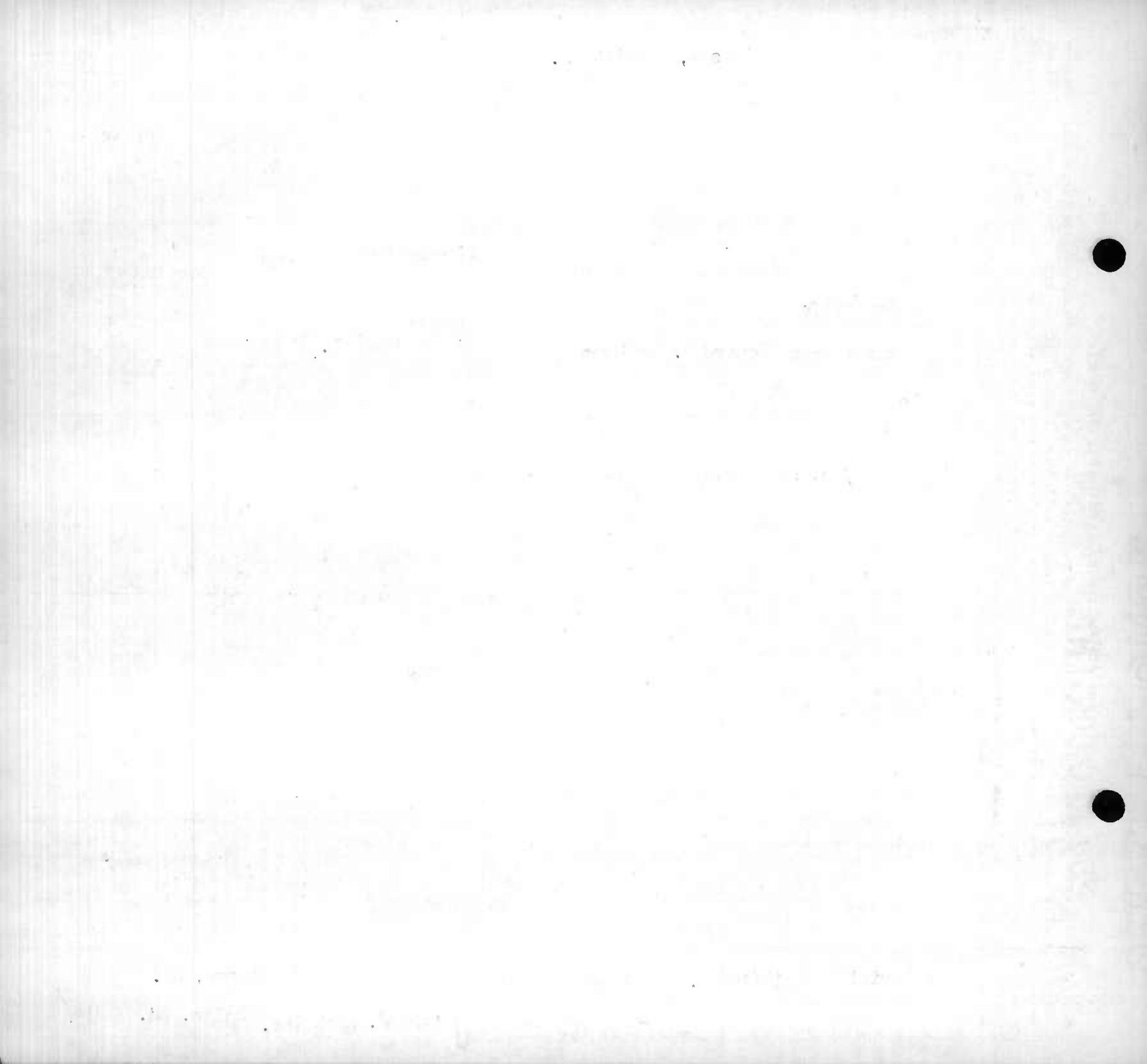




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

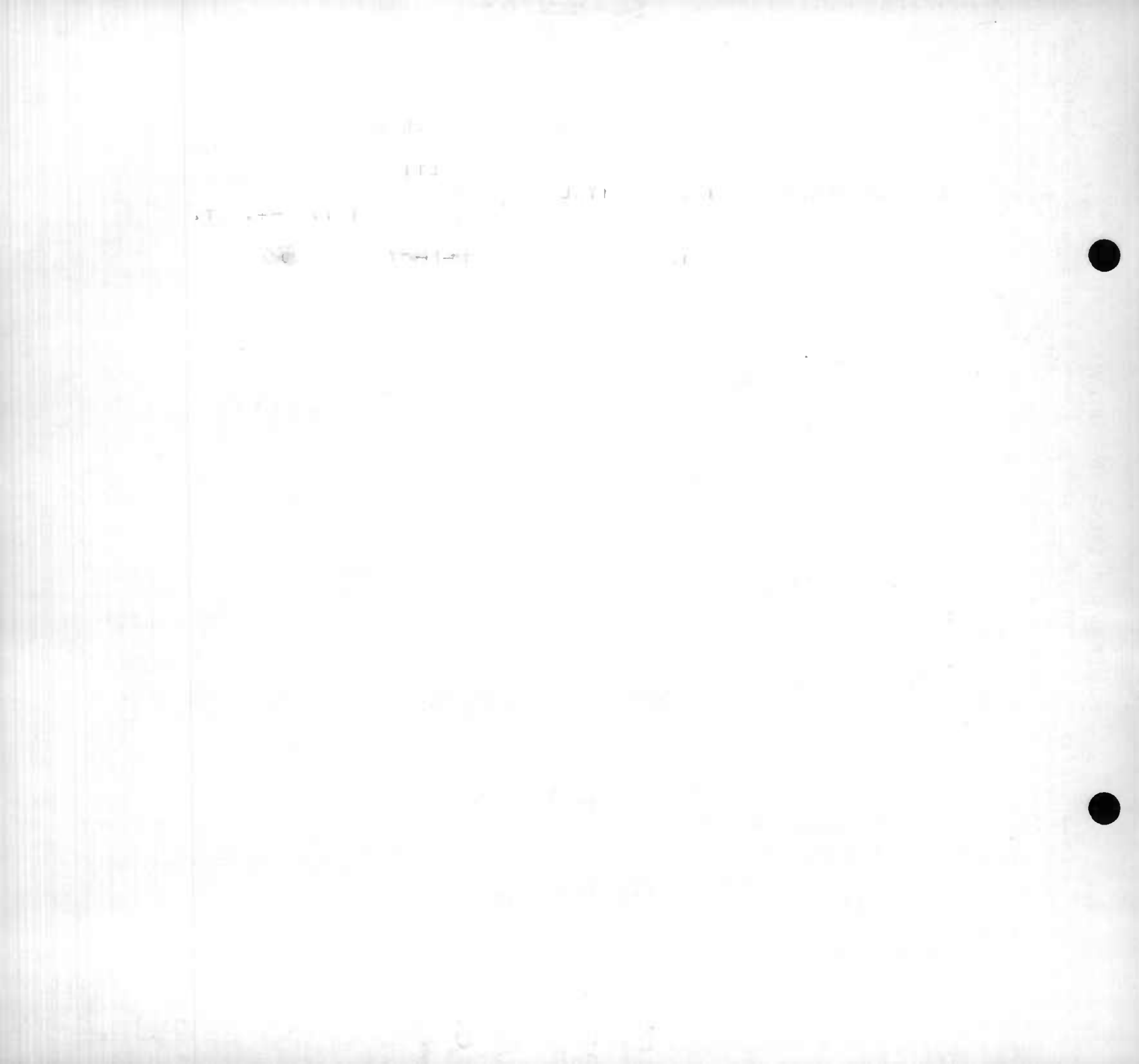
BIRTH NO.		66 10314		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10314	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				Lindsay, Edith L.			
2. DATE AND HOUR OF DEATH				Oct. 10 1966 6:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
36 Franklin Square Hospital				Maryland Balt. Co.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore #4 53-00			
D. STREET ADDRESS (If rural, give location)				8327 Wyton Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 1 Yr. Hours
F	W.	married	11-28-'17	48			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Baltimore, MD.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
? <del>xxxxxx</del> Howard D. McCleary				Edith L. <del>John</del> Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Hospital chart.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO		2 days	
				(B) DUE TO			
				(C) DUE TO		years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arteriosclerotic coronary heart disease, severe			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Oct. 9 1966 to Oct. 10 1966, that (I) (we) last saw the deceased alive on Oct. 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
K. B. Lee M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				Oct 10 1966.			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
K. Bum Lee M.D.				Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/14/66.		Parkwood Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 13 1966		Robert E. Fickman		Leonard J. Ruck Inc.		Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10315	
BIRTH NO. 66 10315		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY BROOKS		2. DATE AND HOUR OF DEATH 10/11/66 3:10 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write FULLY and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		123 HENRIETTA AVE. ST.	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-16-09	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pasadena, Maryland	
13. FATHER'S NAME GEORGE BROOKS		14. MOTHER'S MAIDEN NAME SARAH JOHNSON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-3994		17. INFORMANT Mrs. Elsie Green Rt 4 Box 489 Pasadena, Md	
18. 453.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) CARDIAC ARREST DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) UREMIA			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/26 to 10/11 19 66 and that (I) (we) last saw the deceased alive on 10/11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth L. Brigham				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) KENNETH L. BRIGHAM				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-15-66		24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Margothy	
OCT 13 1966		1701 Laurens St		1701 Laurens St	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10316</b>	
66 10316				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Cora Bartlett Powell		October 10, 1966   11 <sup>20</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION  90 Long Green Nursing Home		(If not in hospital or institution, give street address or location)		Maryland	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		4227 Wickford Road	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	W	Never Married	3/26/1877	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None		None		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Alfred H. Powell		Cora Waring		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Miss Ellen P. Orriek, 4227 Wickford Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334 X I		Generalized and Cerebral Arteriosclerosis			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 52 to 19 66, that (I) (we) last saw the deceased alive on Oct 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Walter B. Buck				10/11/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Walter B. Buck		18 E. Eager St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10/12/66		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Frank C. Schmidt

2. DATE AND HOUR PRONOUNCED DEAD

10/11/66 6:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

**CERTIFICATE AMENDED**  
 FULL NAME OF (If not in hospital or institution, give street  
 HOSPITAL OR ADDRESS OR LOCATION)  
 INSTITUTION  
 10-20-66  
 42  
 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore  
6049 Gwynn Oak Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Dec. 12, 1891

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired - Levy Straw Hat Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Charles J. Schmidt, Sr.

14. MOTHER'S MAIDEN NAME

Anna Koehler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-10-0973

17. INFORMANT

ADDRESS

Charles J. Schmidt, 1320 Windemere Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Graniocerebral injury

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Liberty and Baltimore Sts.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year)

10 5 66

(Hour)

8:30 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

apparently fell on back of head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/11/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/14/1966

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

H.W. Jenkins & Sons Co. 4905 York Rd.  
Baltimore 12, Md.

Divorce Decree submitted dated May 10, 1922  
10-20-66 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10318</u>	
BIRTH NO. <u>66 10318</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ROBINSON, WILLIAM J.</u>		2. DATE AND HOUR OF DEATH <u>Oct 12, 1966 at 4:55pm</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill NURSING &amp; Convalescent Center</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>HAMPDEN ST.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2621 HAMPDEN STAVE.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>SEPT. 20-1903</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NGHT WATCHMAN-RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ART MUSEUM</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HENRY O. ROBINSON, SR.</u>		14. MOTHER'S MAIDEN NAME <u>MARY BARRON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-22-7902</u>		17. INFORMANT (Sister) ADDRESS <u>MRS. JAMES HAYDEN 2621 HAMPDEN ST</u>	
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>MSAD</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March</u> 1966 to <u>Oct 12</u> 1966, that (I) (we) last saw the deceased alive on <u>Oct 12</u> 19 66 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>FM. DUGAN</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Oct 12 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>FM. DUGAN</u>		23D. ADDRESS M.D. <u>15 E BIDDLE ST BALTIMORE MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/15/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore, 12, Md.</u>			

DATE: 12-1-1963  
221 HANCOCK ST.

201-20-1903 62

BATIMORE, MD.

MARY BARON  
(JANE)  
MRS. JAMES HADON

Box 1141 New York  
CONVENT CENTRE

M W SINGLE

WANT WORK

HENRY O ROBINSON

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10319		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10319	
1. NAME OF DECEASED (Type or Print) <b>Sue HENDRY Hammond</b>			2. DATE AND HOUR OF DEATH <b>10/12/66 1:55 PM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4803 Keswick Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>4/16/20</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTH PLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>H. A. Hendry</b>			14. MOTHER'S MAIDEN NAME <b>Edna Longford</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-28-7849</b>	17. INFORMANT <b>Charles Willis Hammond</b>		ADDRESS <b>(Same)</b>
18. I <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cancer of the breast,</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>with widespread metastases</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>9/8/ 1966</b> to <b>10/12/ 1966</b> , that (I) <b>we</b> last saw the deceased alive on <b>10/12 1966</b> and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>We</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard J. Owellen</b> M.D.				23B. DATE SIGNED <b>10/12/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard J. Owellen</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/17/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION <b>Woodlawn, Balto. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co</b>			
25D. ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>					

Conc. of the breast  
with widening  
arteries

1872

Robert H. Smith

cc

0

0

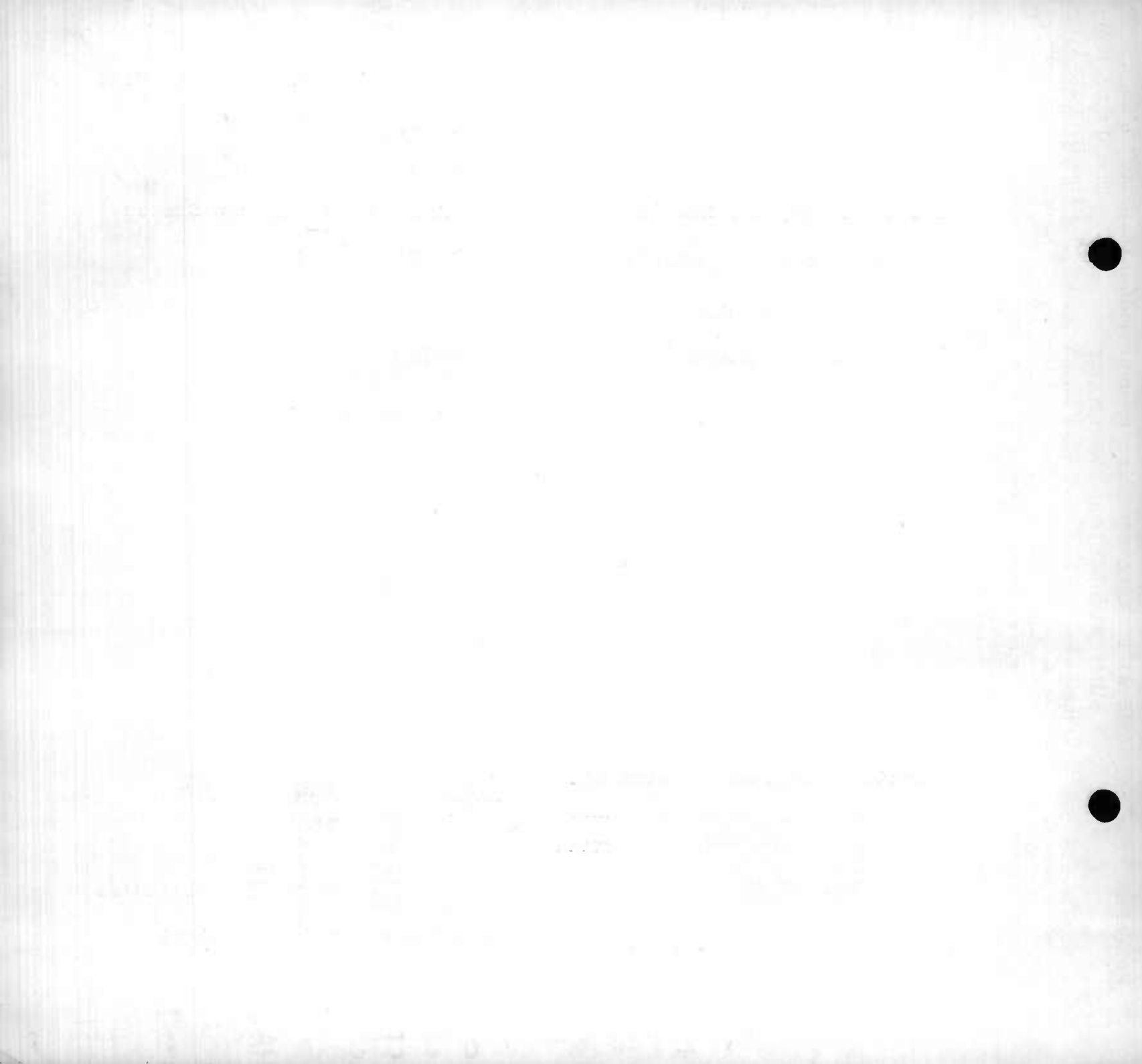
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10/12/12

The Johns Hopkins  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10320				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10320	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Sandra Cornwell				2. DATE AND HOUR OF DEATH 10/10/66 6:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 412 North Washington Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/30/32	9. AGE (In years lost birthday) 34	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alfonso Brown				14. MOTHER'S MAIDEN NAME Daisy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Johnnie Cornwell Louis		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) myocardial infarction				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH an hour	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) Patient deceased on arrival.		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/10 19 66 to 10/10 19 66, that (I) (we) lost saw the deceased alive on --- 19 --- and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death.							
23A. SIGNATURE Tah-Hsiung Hsu				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/10/66	
23C. PHYSICIAN'S NAME (Type) Tah-Hsiung Hsu		23D. ADDRESS The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-14-66		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat Cent		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Shay Wilson 1000 Bessie Taylor Ave		ADDRESS	





66 10321

BALTIMORE CITY HEALTH DEPARTMENT

66 10321

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANCELLA

CHILDS

2. DATE AND HOUR PRONOUNCED DEAD

October 8, 1966

4:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 850 W. Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

850 W. Fayette Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

July 1 - 1909

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Clarence Childs

14. MOTHER'S MAIDEN NAME

Rose Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-10-8983

17. INFORMANT

ADDRESS

Lorraine Blum 1128 Heller St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) \_\_\_\_\_  
DUE TO

Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-13-66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cmt

23D. LOCATION

Brooklyn

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

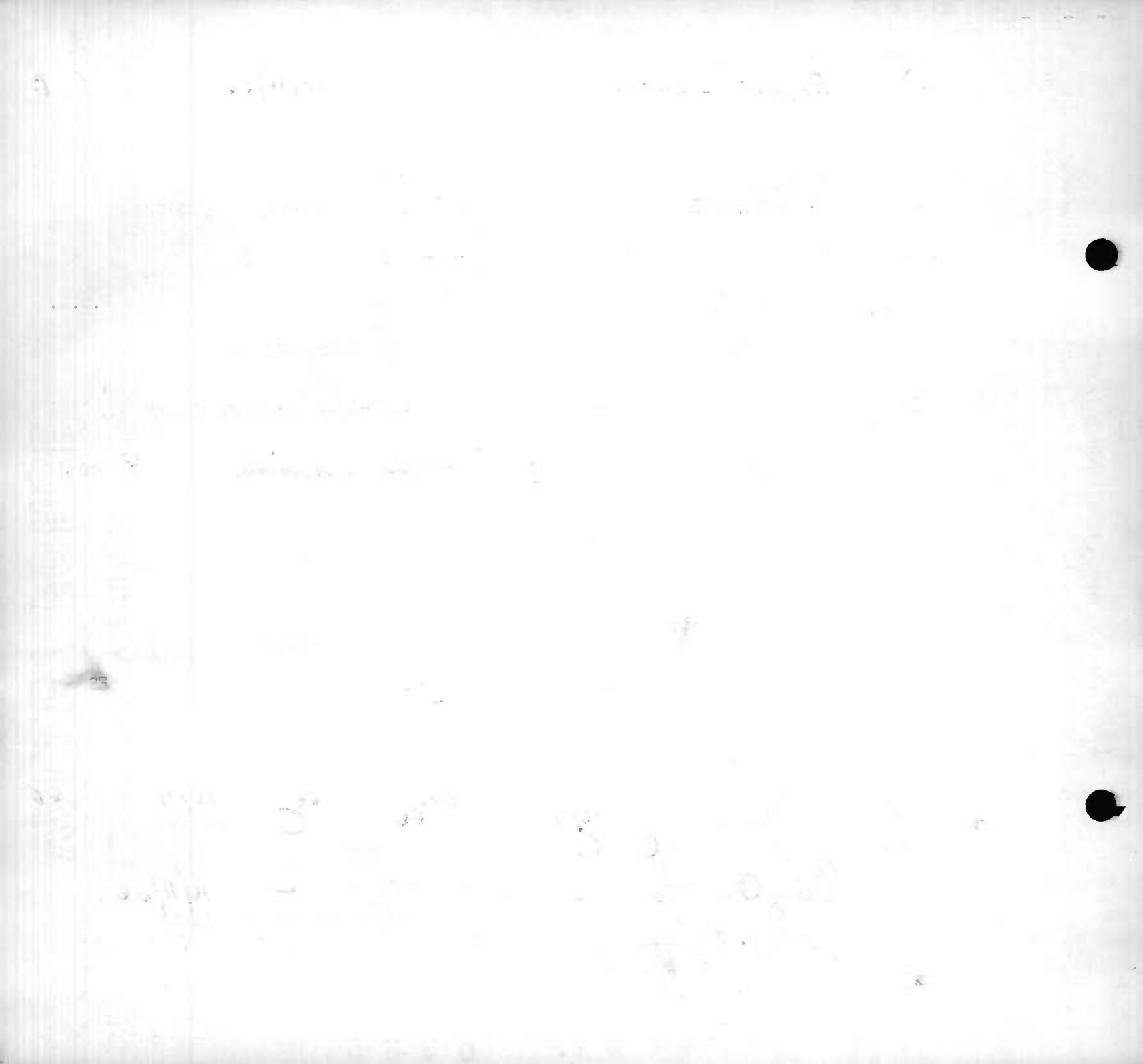
VALLEY FORCE

APPOINTMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

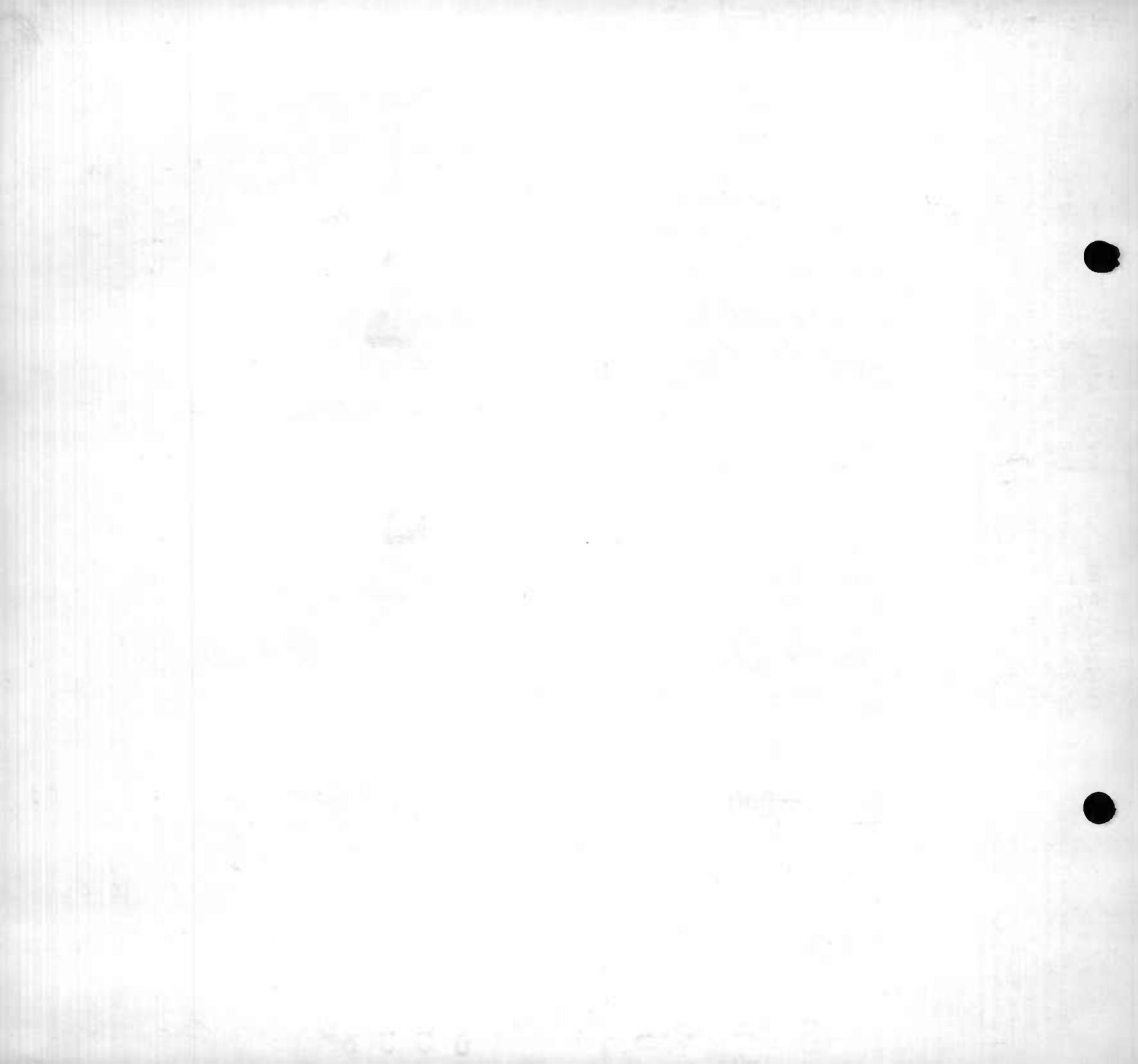
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 10322</b>	
BIRTH NO. <b>66 10322</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ERNEST SLATER</b>	
2. DATE AND HOUR OF DEATH <b>10/11/66 8 P.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		5. SEX <b>Male</b>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		6. RACE <b>Negro</b>	
D. STREET ADDRESS (If rural, give location) <b>1519 Aisquith Street 21202</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		8. DATE OF BIRTH <b>10-10-1923</b>	
9. AGE (In years lost birthday) <b>43</b>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		10B. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Gus</b>	
14. MOTHER'S MAIDEN NAME <b>Laura Wilson</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>	
16. SOCIAL SECURITY NO. <b>218-50-0919</b>		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Brachogenic Carcinoma</b> (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>8 mo.</b>		19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>WHERE DID INJURY OCCUR?</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>9/16/66</b> to <b>10/11/66</b> , that (I) (we) lost saw the deceased alive on <b>10/11/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Craig A. Johanson</b>		23B. DATE SIGNED <b>10/11/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Craig A. Johanson</b>		23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-17-66</b>	
24C. NAME of CEMETERY or CREMATORY <b>Balto not Carl</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>10-18-1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Choy Wilson</b>		ADDRESS <b>1000 Brantley Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10323	
BIRTH NO. 66 10323		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Hudnell Lorenza Rema</i>		2. DATE AND HOUR OF DEATH <i>Oct 11 1966</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURA and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>3906 Cedar Dale Road</i>		D. STREET ADDRESS (If rural, give location) <i>3906 Cedar Dale Road</i>			
5. SEX <i>male</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widower</i>	8. DATE OF BIRTH <i>Feb 17 - 1897</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ophelia Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		13. FATHER'S NAME <i>Silas Hudnell</i>		14. MOTHER'S MAIDEN NAME <i>Anna Conway</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Hudnell</i> ADDRESS <i>Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>ASHO C Cong. Failure 23 Months.</i>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>10/10</i> 19 <i>66</i> to <i>10/10</i> 19 <i>66</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>10/10</i> 19 <i>66</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did not)</del> view the body after death.			
23A. SIGNATURE <i>J. Preston Grant</i> M.D.		23B. DATE SIGNED <i>10/13/66</i>		23C. PHYSICIAN'S NAME (Type) <i>J. Preston Grant</i> M.D.	
23D. ADDRESS <i>601 N. Carrollton</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-17-66</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Balto Cent</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 13 1966</i>	
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Gray Wilson</i>		25D. ADDRESS <i>1000 Brentwood Dr</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10324		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10324	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 10/10/66 4:10 PM	
1. NAME OF DECEASED (Type or Print) HALL, EARL ALLEN		2. DATE AND HOUR OF DEATH		DR. J. K. HARRIS	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived in institution: residence before admission)		A. STATE Md B. COUNTY 33-32-02 M M	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 11-04		D. STREET ADDRESS (If rural, give location) 1301 MADISON AVE	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/5/17	9. AGE (In years last birthday) 49	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME MARIE HALL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NW		16. SOCIAL SECURITY NO. 215-12 5360		17. INFORMANT LELIA HALL 4014 GELSTON DR	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Pulmonary Embolus		35 minutes	
ANTECEDENT CAUSES		(B) Myocardial Infarction		3 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD		undetermined	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/39 to 10/10 1966 that (I) (we) last saw the deceased alive on 10/10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
24J. ADDRESS		24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR	

At 100

11

49

N 2 K

Reservoir

Cont

over 200 feet in height

no

Remains of the old  
reservoir



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10325</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>66 10325</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <u>FRANKS, LATACEA R.</u>			2. DATE AND HOUR OF DEATH <u>10-9-66. 12<sup>10</sup> P. M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u> <u>38</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>8-02</u> D. STREET ADDRESS (If rural, give location) <u>1841 N. MONTFORD AVE.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEWBORN</u>	8. DATE OF BIRTH <u>8-31-66</u>	9. AGE (In years last birthday) <u>1</u> <u>10</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		
11. BIRTHPLACE (State or foreign country) <u>USA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>ALFRED FRANKS.</u>			14. MOTHER'S MAIDEN NAME <u>GOLDIE WILSON.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>CHART # 334456.</u>		17. INFORMANT ADDRESS <u>CHART # 334456.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>LOWER NEUTRON NEPHROSIS</u> DUE TO <u>DEHYDRATION &amp; SHOCK.</u> DUE TO <u>GASTROENTERITIS.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 HRS.</u> <u>18 HRS.</u> <u>2 DAYS</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>HE</u> (this hospital) attended the deceased from <u>10-8</u> 19 <u>66</u> to <u>10-9</u> 19 <u>66</u> , that <u>HE</u> (we) last saw the deceased alive on <u>10-9</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>HE</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Albert M. Jordan</u>				23B. DATE SIGNED <u>10-9-66.</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/1/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>no burial</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (State) <u>Md.</u>		24F. LOCATION (Country) <u>USA</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>no burial</u>		25C. FUNERAL DIRECTOR ADDRESS <u>638 N. Green St</u>	

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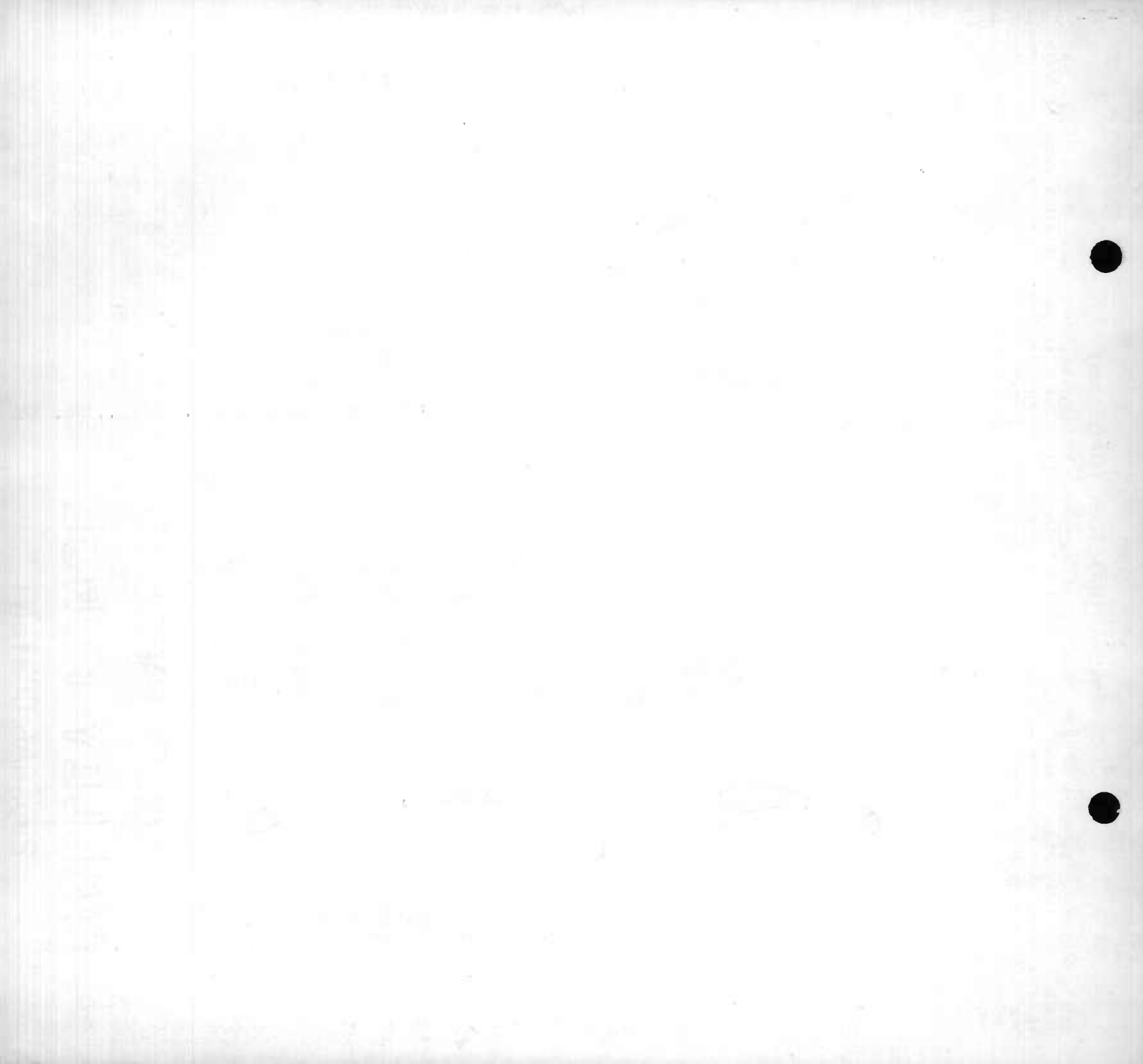
Handwritten text at the bottom of the page, possibly a footer or signature.

ante Clayton

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

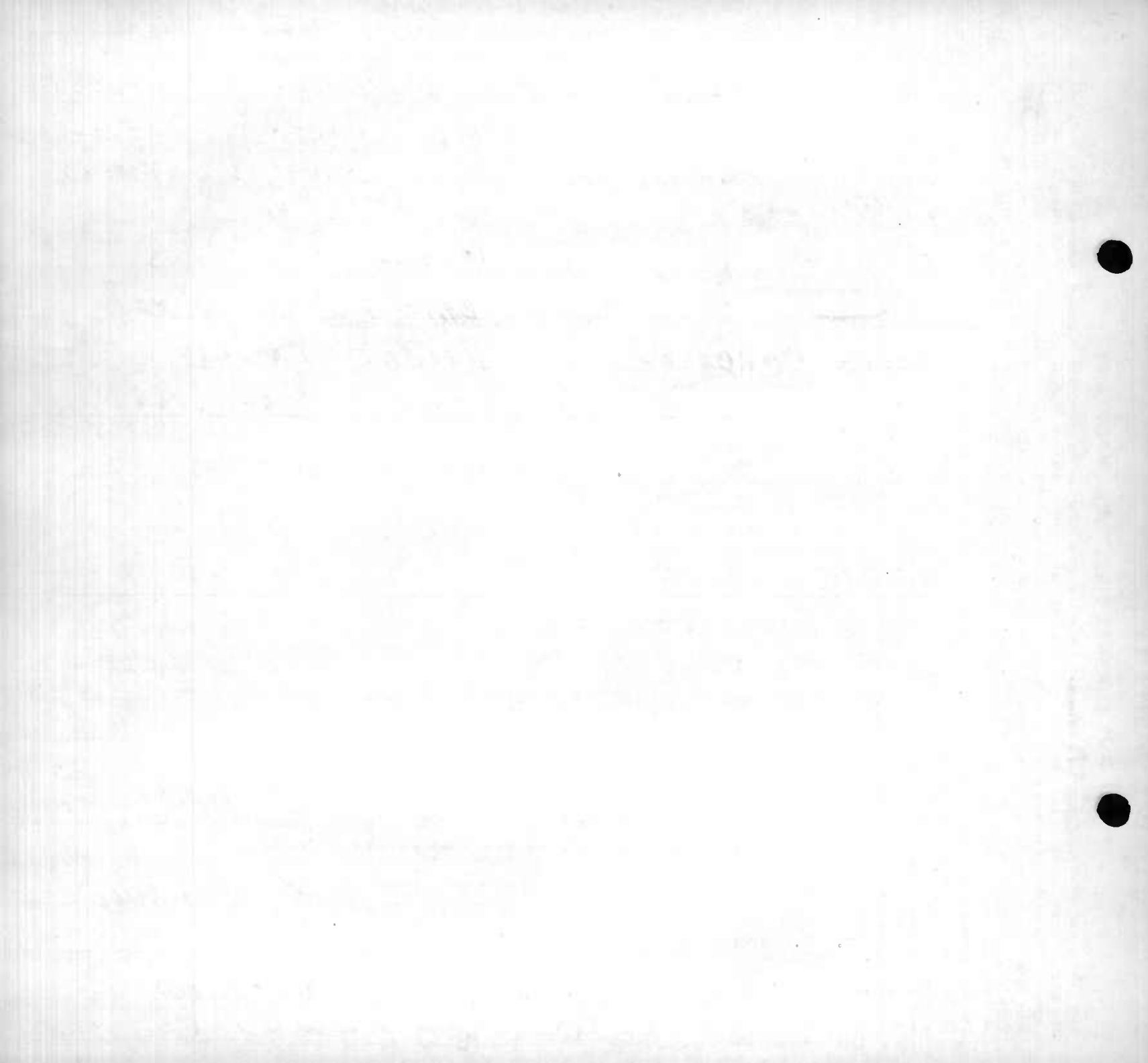
BIRTH NO. 66 10326		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Victoria Coleman		2. DATE AND HOUR OF DEATH 10/19/66 2:47 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 705 Winston Ave #2122	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 6-20-65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 yr 4 mos
13. FATHER'S NAME unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		14. MOTHER'S MAIDEN NAME unknown	
16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS DEPT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO enanthem - diencephalic synd (B) DUE TO hydrocephalus with (C) DUE TO med brain spongioblastoma	
19A. DATE OF OPERATION Aug 27 - Sept 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED B and C above	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) nurse		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from August 15, 19 66 to October 9, 19 66, and that (1) (we) lost saw the deceased alive on October 9, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.			
23A. SIGNATURE A. Silver		23B. DATE SIGNED 10/19/66	
23C. PHYSICIAN'S NAME (Type) Ann Louise Silver		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/14/66	
24C. NAME of CEMETERY or CREMATORY St Stephens		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. OCT 14 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Dorothy P. Taylor		25D. ADDRESS 356 Gwynor	



# FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10327</u>	
BIRTH NO. <u>66 21707</u>		<b>CERTIFICATE OF DEATH</b>		DATE AND HOUR OF DEATH <u>10/11/66</u> <u>2:40 P.M.</u>	
M.E. CASE NO. <u>66 10327</u>		1. NAME OF DECEASED (Type or Print) <u>BABY GIRL BARBAKOS</u>		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. AGE (In years last birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF 46 MARYLAND</u>		A. STATE <u>MD.</u> B. COUNTY <u>BALTO - C.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21 (ESSEX)</u>	
D. STREET ADDRESS (If rural, give location) <u>601 SEENA RD</u>		6. DATE OF BIRTH <u>10-9-66</u>		7. AGE (In years last birthday) <u>3</u>	
8. SEX <u>F</u>		9. RACE <u>W</u>		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>—</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		12. KIND OF BUSINESS OR INDUSTRY <u>—</u>		13. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>	
14. FATHER'S NAME <u>LOUIS BARBAKOS</u>		15. MOTHER'S MAIDEN NAME <u>HELENE ENSLI</u>		16. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>—</u>		19. INFORMANT <u>FATHER</u> ADDRESS <u>601 SEENA RD</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>ERYTHROBLASTOSIS FETALIS</u>		<u>?</u>	
(B) <u>—</u>		(C) <u>—</u>		<u>—</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/11/66</u> 19 to <u>10/11/66</u> 2:40 PM that (I) (we) last saw the deceased alive on <u>10/11/66</u> 2:40 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. Reroma</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/11/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. F. Reroma</u>		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-13-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN</u>	
24D. LOCATION (City, town, or county) <u>BALTO MD</u>		24E. STATE (State)		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 14 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fotherman</u>		25C. FUNERAL DIRECTOR <u>John J. Connelly, Esq., Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">66 10328</span>	
BIRTH NO. <span style="font-size: 1.2em;">66 10328</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WOEHLKE, ANNA EDITH</b>		2. DATE AND HOUR OF DEATH <b>10-12-66</b>   <b>6:42</b> <b>A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> <b>WILKENS &amp; CATON AVENUE</b> <b>BALTIMORE 29, MARYLAND</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give town/hip) <b>BALTIMORE</b>			
D. STREET ADDRESS (If rural, give location) <b>417 MAUDE AVENUE</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>12-14-95</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LOIS</b>		14. MOTHER'S MAIDEN NAME <b>CLARA HODGES</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS, WILKENS &amp; CATON AVE.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <b>Cardiac Arrest</b> (B) DUE TO <b>Myoc. Infarction</b> (C) DUE TO <b>ASCVD</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-10-1966</b> to <b>10-12-1966</b> that (I) (we) lost saw the deceased alive on <b>10-12-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>E. WEISS</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/15/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Medow Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 14 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>McCullough of BOE. Jones; #30</b>	

10-11-52

10-11-52

MAINTENANCE

ST. LOUIS

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309



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 66 10329		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10329	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Brown, Thurman</i>	
2. DATE AND HOUR OF DEATH <i>10-10-66</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospital</i> 4940 Eastern Avenue Baltimore, Maryland, 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> CITY OR TOWN <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>814 St. Paul Street 21202</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>4-7-16</i>	9. AGE (In years, last birthday) <i>50</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNEMPLOYED</i>
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>JOHN T. BROWN</i>	
14. MOTHER'S MAIDEN NAME <i>Pearl TURNER</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>231-10-0967</i>	
17. INFORMANT <i>Records: BCH-4940 Eastern Avenue 21224</i>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Bronchogenic CA</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
19. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-28</i> 19 <i>66</i> to <i>10-10</i> 19 <i>66</i> and that (I) (we) lost saw the deceased alive on <i>10-10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>J. Richmond</i>		23B. DATE SIGNED <i>10-10-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. Richmond</i>		23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland 21224</i>		23E. FUNERAL DIRECTOR <i>Charles S. Seiler</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-13-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. CARMEL CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>5712 O'DONNELL ST. BALTO., 24, MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 14 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairman</i>	
25C. ADDRESS <i>6224 EASTERN AVE. BALTO., 21224, MD.</i>		25D. ADDRESS <i>6224 EASTERN AVE. BALTO., 21224, MD.</i>		25E. ADDRESS <i>6224 EASTERN AVE. BALTO., 21224, MD.</i>	

BURIAL 10-13-66 MT. CARMEL CEM. 2715 O'DONNELL ST. BARTON, MD.  
Plaque & grave marker  
BARTON, MD.

231-10-4467

JOHN T. BROWN

TURNER

UNRECORDED LABORER

JOHN T. BROWN

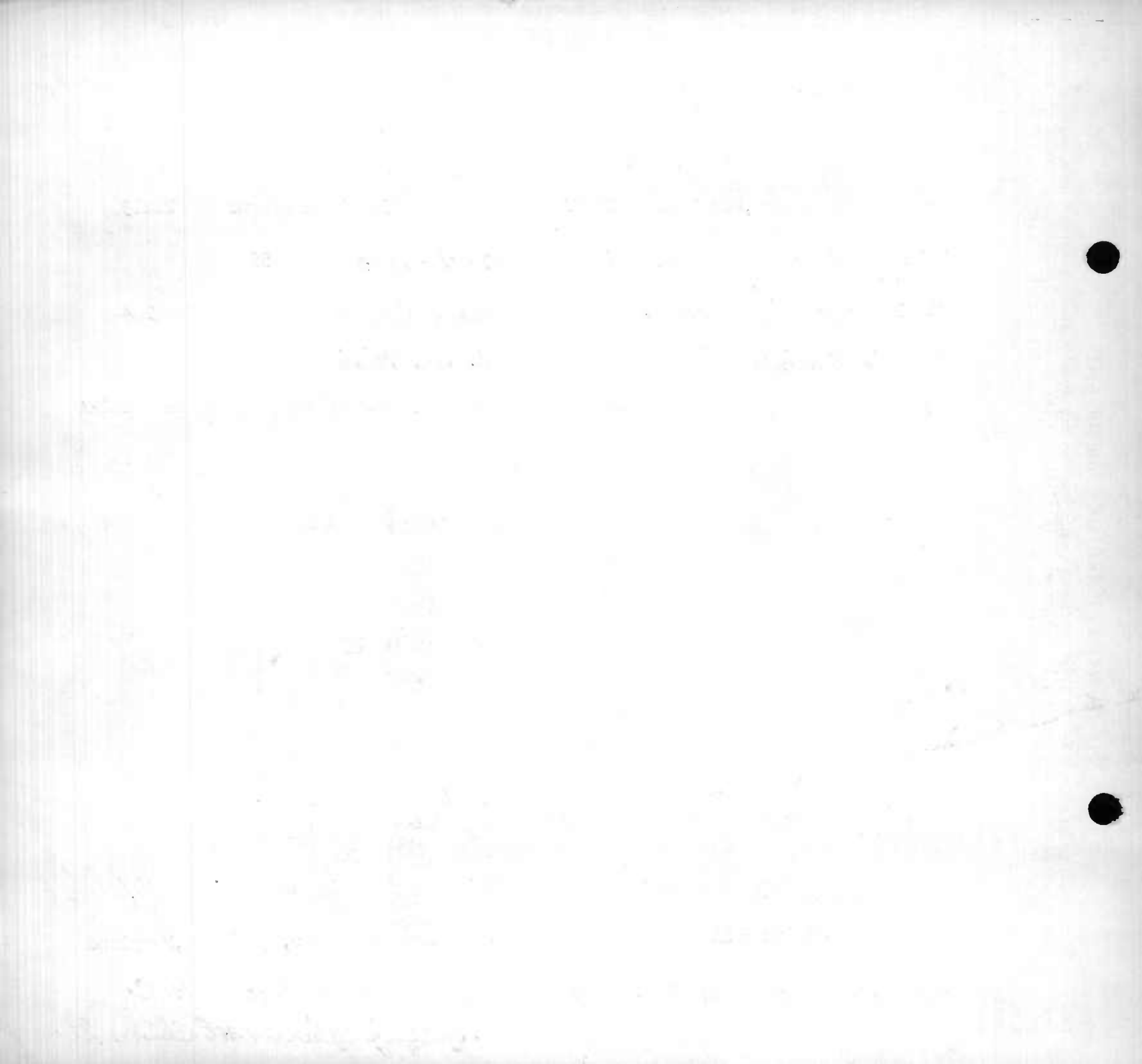
4-1-16 20

## CERTIFICATE OF DEATH

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>William Smith</i>		2. DATE AND HOUR OF DEATH <i>10/10/66 12:15 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2404 Llewellyn Avenue 21213</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2-11-1910</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Steel Co.</i>	11. BIRTHPLACE (State or foreign country) <i>Wake Co., N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Connie Smith</i>			14. MOTHER'S MAIDEN NAME <i>Leona Hieb</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>245-01-7206</i>	17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>491X I</i>		CAUSE OF DEATH (A) <i>CONGESTIVE HEART FAILURE</i> DUE TO (B) <i>ASPIRATION PNEUMONIA</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CEREBRAL ANOXIA</i>		<i>3 days</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/6/66</i> to <i>10/10/66</i> , that (I) (we) last saw the deceased alive on <i>10/10/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Judith Hall</i>				23B. DATE SIGNED <i>10/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Judith Hall</i>		23D. ADDRESS M.D. <i>4940 Eastern Avenue, Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>10-14-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Eagle Rock Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Eagle Rock, N.C.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Randolph J. Collock</i>		25D. ADDRESS <i>2431 E. Oliver St.</i>	



B-520

66 10331

BALTIMORE CITY HEALTH DEPARTMENT

66 10331

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

HENRY L. BAINES

2. DATE AND HOUR PRONOUNCED DEAD

8 October 10, 1966 4:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1507 N. Lakewood Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

10-14-1910

9. AGE (In years last birthday)

55

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lamp Baines

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

243-16-4150

17. INFORMANT

ADDRESS

Mrs Beadie Baines 1507 Lakewood Ave

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Rudiger Breitenecker, MD

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10-13-66

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. PK.

23D. LOCATION (City, town, or county) (State)

Arbutus Memorial PK.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALLEN BROTHERS

1000 DO NOT

U.S.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10332</span>	
BIRTH NO. <span style="float: right;">66 10332</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Eva (Evdoxia) Ricas Karavedas</b>		2. DATE AND HOUR OF DEATH <b>Oct. 10, 1966</b>   <b>1:00 a</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION  <b>00</b> <b>4803 York Road</b> <b>Baltimore, Md. 21212</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> <b>21212</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4803 York Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>4-11-1966</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Kalozorantse, Apiros</b>	
13. FATHER'S NAME <b>Leonidas Bays</b>			14. MOTHER'S MAIDEN NAME <b>Alexandra Tsamis</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-40-1702</b>		17. INFORMANT ADDRESS <b>Dionicios Karavedas (Husband) Same</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>Metastatic Sarcoma to Brain &amp; Lungs</b> 5 months DUE TO (B) <b>Advanced Uterine Sarcoma</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>May 12, 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Uterine Sarcoma</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 6, 1966</b> to <b>October 10th, 1966</b> , that (I) (we) last saw the deceased alive on <b>October 9, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <i>Stephen K. Padussis</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>October 11, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stephen K. Padussis</b>		23D. ADDRESS M.D. <b>Medical Art Bldg.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/1966</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Eugenia K. Seitz</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Seitz Funeral Home Baltimore, 21212</b>			

**OCT 14 1966** *Robert E. Seitz*



WATKINS HOUSE

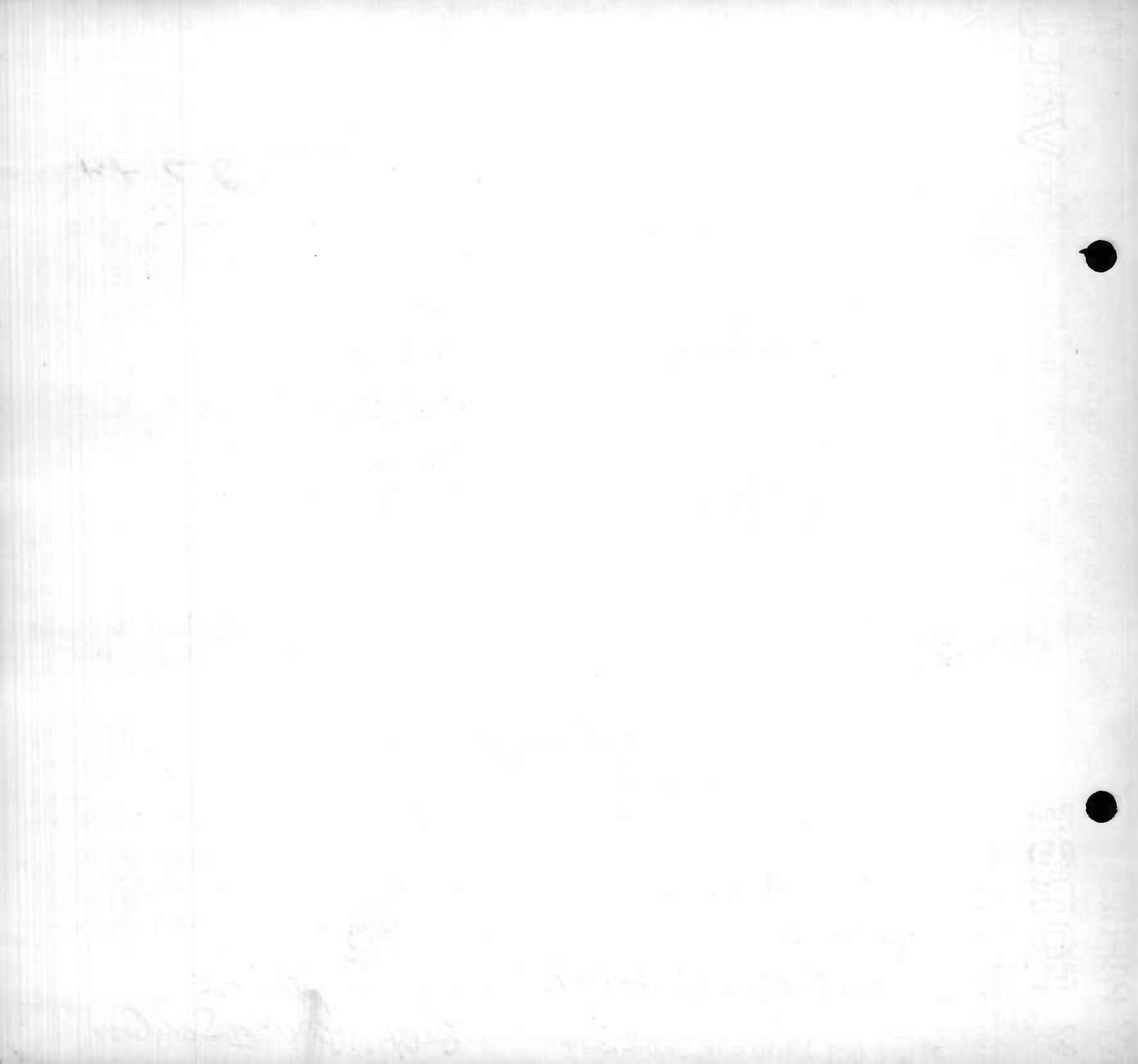


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10333	
66 10333				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Michael Thalheimer		10.12.66		9:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location		A. STATE MD.			
90 Little Ses of The Poor 1200 VALLEY ST BALTIMORE MD 21202		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 10-01			
		D. STREET ADDRESS (If rural, give location) 1200 VALLEY ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
M	W		2.19.1883	23	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TAILOR				BALTIMORE MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Thalheimer		Catherine SAENG		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
?		218-01-0695		Little Ses of The Poor	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1. 163X I		Terminated Cancer of the lungs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 10.11.1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Justin Kudrka				23B. DATE SIGNED Oct 12.66	
23C. PHYSICIAN'S NAME (Type) Justin Kudrka				23D. ADDRESS 2151 Wilkens Ave Baltimore MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/14/66		Holy Redeemer Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		Robert E. Johnson		Philip Herwig Sons Orleans St 2024	

OCT 14 1966



BIRTH NO.

66 10334

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 10334

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ERIC TODD PRICE

2. DATE AND HOUR PRONOUNCED DEAD

October 12, 1966 5:00 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)43  
South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

114 W. Clement Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 20, 1961

9. AGE (in years  
last birthday)

5

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

John R. Price

14. MOTHER'S MAIDEN NAME

Lois M. Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Mrs. Lois M. Price

ADDRESS

114 W. Clement St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Transection of Medulla Oblongata  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Fracture of Upper Cervical Vertebrae.  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Clarkson and Clement Streets

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9 12 '66 P

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/13/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10 17 1966

23C. NAME of CEMETERY or CREMATORY

Holy Cross

23D. LOCATION

(City, town, or county)

Brooklyn, A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 14 1966

Mc Cully

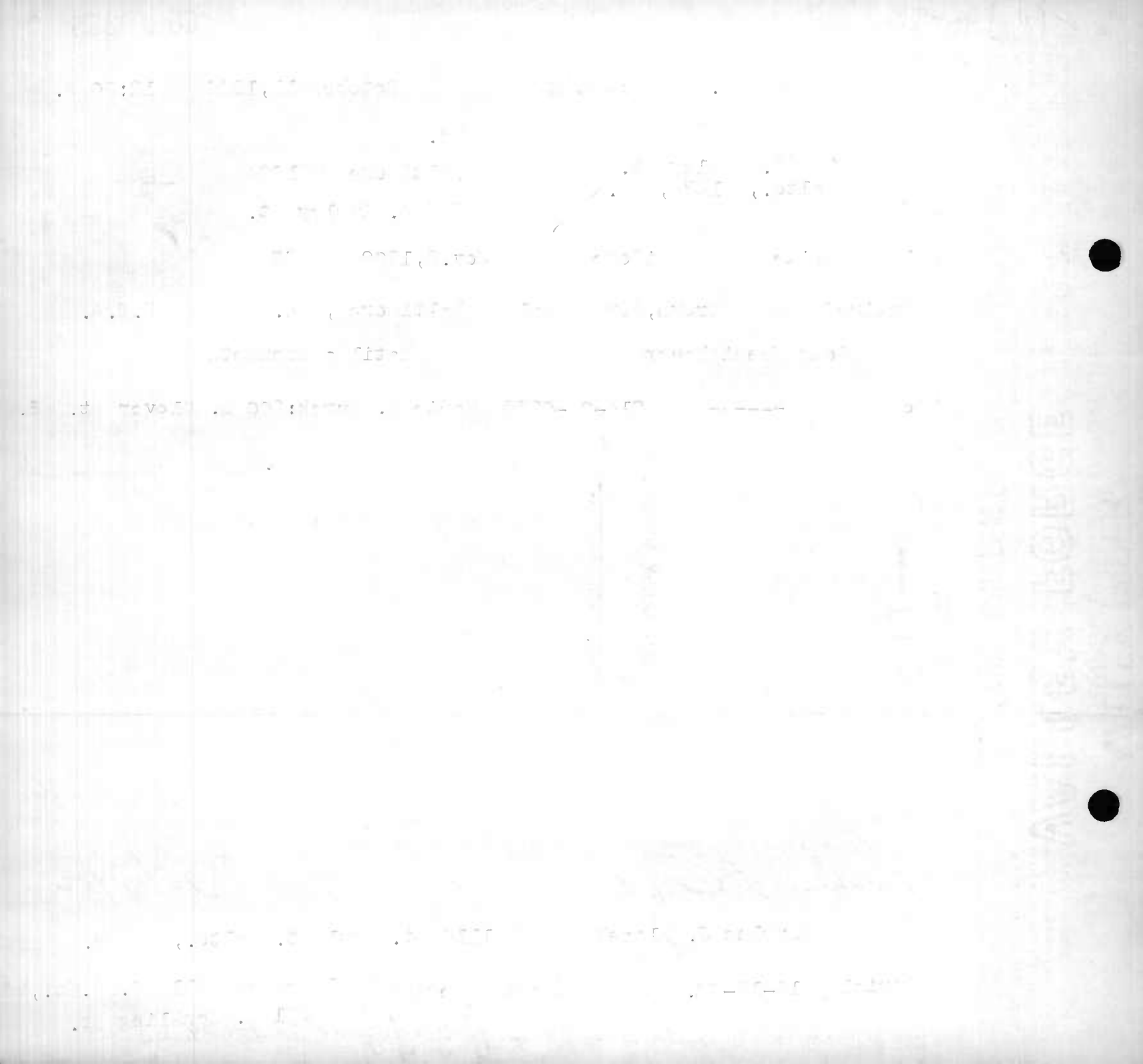
130 E. Fort Ave

VALLEY FORGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-521 66 10335		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10335	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
66 10335				JOHN H. KOENIGBAUER	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		October 11, 1966 12:30 P. M.	
00 735 S. Gurley St. Balto., 21224, Md.		Md.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore # 21224	
		D. STREET ADDRESS (If rural, give location)		735 S. Gurley St. 1-01	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	Widowed	Nov. 5, 1902	63	Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
		Crown, Cork & Seal	Baltimore, Md.	U. S. A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Koenigbauer			Matilda Kuemmeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		214-03-0755	Marie M. Turek; 800 N. Glover St. # 5.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, apnoea, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		Coronary Thrombosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		Coronary sclerosis	
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 57 to 10/11 19 66, that (I) (we) last saw the deceased alive on 5/7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles J. Blazek				10/12/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Charles J. Blazek		1116 St. Paul St. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10-13-66		Sacred Heart Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 14 1966		Charles J. Blazek		901 S. Corkling St. BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 10336		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10336	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				Iwan Seniuta	
2. DATE AND HOUR OF DEATH		October 12 1966 10:07 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
Church Home + Hospital		Maryland			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED	
Male		White		WIDOWED, DIVORCED (specify)	
				Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Choir Conductor		St. Michael Church		Ukraine Europe	
12. CITIZEN OF WHAT COUNTRY?		American			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joseph Seniuta		Maria Lewicky			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		182-26-3605		Alexandria Seniuta (wife)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Metastatic Adenocarcinoma of Liver.			
ANTECEDENT CAUSES		(B) Adenocarcinoma of Stomach.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9-9-66		Gastrointestinal bleeding		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from August 8th 1966 to October 12th 1966, that (I) (we) last saw the deceased alive on October 12th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. A. E. Subong, Jr.				10-12-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. A. E. Subong, Jr.		Church Home + Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10-15-1966		St. Michael Ukrainian	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 14 1966		Robert E. Farkner		Lilly & Zeller Inc. 1901-07 Eastern Ave.	



Dr. A. F. Simpson

Chlorine for + test

✓

October 15th 06 August 8th to October 15th 06

08-9-06 Gastrointestinal bleeding 100

Abnormalities of stomach  
of time  
Metastatic tuberculosis

Alexander Semits (wife)

Maria Lewicki

Europe American

Mate White married

2-5-87 79

310 S. Wolfe St  
Baltimore MD

Church Home + Hospital



E-1640

66 10337

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10337

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EARLEY, CORNEL

2. DATE AND HOUR PRONOUNCED DEAD

October 11, 1966 8:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1716 McCulloh Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

3-2-1957

9. AGE (In years  
last birthday)

9

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Melvin Earley

14. MOTHER'S MAIDEN NAME

Yvonne Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL  
SECURITY NO.

---

17. INFORMANT

ADDRESS

Melvin Earley - 1716 McCulloh St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchial asthma  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

October 12, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-15-66

23C. NAME of CEMETERY or CREMATORY

Carver Memorial Park

23D. LOCATION

(City, town, or county)

Laurel, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

OCT 14 1966 10:26 AM 3 0 3 5 0

VALLEY FORT

## CERTIFICATE OF DEATH

Registered No. 66 10338

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

FRONIA

BODDIE (Sophronia)

2. DATE AND HOUR OF DEATH

10/10/66

10<sup>15</sup> P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

MARYLAND GENERAL HOSPITAL

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2311 DRUID HILL AVE

5. SEX

F

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10/24/05

9. AGE (In years  
lost birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

DOMESTIC WORKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

CALVIN PARSONS

14. MOTHER'S MAIDEN NAME

ELLA ?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

HUSBAND

ADDRESS

SAME

18.

157X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)(A) METASTATIC CARCINOMA TO LIVER  
DUE TO

UNKNOWN

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) CARCINOMA OF HEAD OF PANCREAS  
DUE TO

UNKNOWN

(C) RHEUMATIC VALVULAR DISEASE

(MITRAL) WITHOUT DECOMPENSATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

9/22/66

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

CARCINOMA OF PANCREAS

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Initally medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/5/1966 to 10/10/1966,  
that (I) (we) last saw the deceased alive on 10/10/1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John P Doerfer

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/10/66

23C. PHYSICIAN'S  
NAME (Type)

JOHN P DOERFER

M.D.

23D. ADDRESS

MARYLAND GENERAL HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (specify)

Burial

24B. DATE

10-15-66

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

OCT 14 1966

66 10338

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MARYLAND GENERAL RECORDS  
JAN 20 1910

10/24/07

VIRGINIA

ELSA

HUSBAND

RECEIVED - RETURN TO THE

RECORDS OF THE

RECORDS OF THE

RECORDS OF THE

10/24/07

10/24/07

10/24/07

JOHN F. DOERFER

for P. H. H. H.

1  
G-615

66 10339

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10339

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Roscoe Griffin

2. DATE AND HOUR PRONOUNCED DEAD

10/7/66 12:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

917 Leadenhall St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

m

8. DATE OF BIRTH

1913

9. AGE (in years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

L

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M.D.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank Powell

14. MOTHER'S MAIDEN NAME

Maggie Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

John Ward 1324 N. Chestnut St.

18. 527.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Cor pulmonale  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Pulmonary emphysema  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/7/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/12/66

23C. NAME OF CEMETERY or CREMATORY

Int. Calvary

23D. LOCATION

(City, town, or county)

(State)

2 a 20 ma

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 14 1966

John E. Fairley, M.D.

Werner U. Spitz, M.D.

108 W. N. Broadway

19660030352

1915

WALLACE ROBERTSON  
SAS COMPANY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10340	
BIRTH NO. 66 10340		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Naomi Stewart</i>		2. DATE AND HOUR OF DEATH <i>10-13-66 9:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>23-01</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1014 headenhall St.</i>	
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>5-1892</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Aaron Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Cassie Cooper</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Interventricular Cardiac</i> DUE TO <i>Vascular disease</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2 None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>9-20</i> 19 <i>66</i> to <i>10-13</i> 19 <i>66</i> , that <del>the</del> (we) last saw the deceased alive on <i>10-13</i> 19 <i>66</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William F. Brather</i> M.D.				23B. DATE SIGNED <i>10-13-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>William F. Brather</i>		23D. ADDRESS <i>South Baltimore General Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/17/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn St</i>	
24D. LOCATION (City, town, or county) <i>Balt City</i>		24E. STATE (State) <i>Md</i>		24F. ZIP CODE <i>21201</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 14 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>J. Brown for 08 Wm Montgomery H</i>	
25D. ADDRESS					

Dear Mr. [illegible]

Yours

Wm. [illegible]

Wm. [illegible] 18 [illegible]



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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Approved by medical Exa-  
To Release  
Per Dr. C. Classen  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10342	
BIRTH NO. 66 10342				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Amelia Shaw</i>		2. DATE AND HOUR OF DEATH <i>10/13/66 6:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore City</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 26-01</i> D. STREET ADDRESS (If rural, give location) <i>4618 White AVE NW</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>01-04-07 59</i>	9. AGE (In years last birthday) <i>59</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore County</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Michael Roitz</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Amps</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS <i>Mr. Howard C. Shaw Same as above</i>	
18. <i>451X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <i>Abdominal Ruptured Aortic Aneurysm 2 days</i> <i>ASCVD</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>10/12/66</i>		19B. CONDITION WHEN OPERATION WAS PERFORMED <i>Ruptured Abdominal Aortic Aneurysm</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>No</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/12/66</i> 19 <i>66</i> to <i>10/13</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/13</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Charles H. Classen, Jr. M.D.</i>				23B. DATE SIGNED <i>10/13/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Charles H. Classen</i>				23D. ADDRESS <i>The Union Memorial Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/17/1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>	
24D. LOCATION <i>Pikesville, Md.</i>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <i>Wm. J. Fickner &amp; Sons</i>	
24G. FUNERAL DIRECTOR <i>Wm. J. Fickner &amp; Sons</i>		24H. ADDRESS <i>Baltimore, Md. north &amp; Pa.</i>		24I. DATE REC'D BY HEALTH DEPT.	

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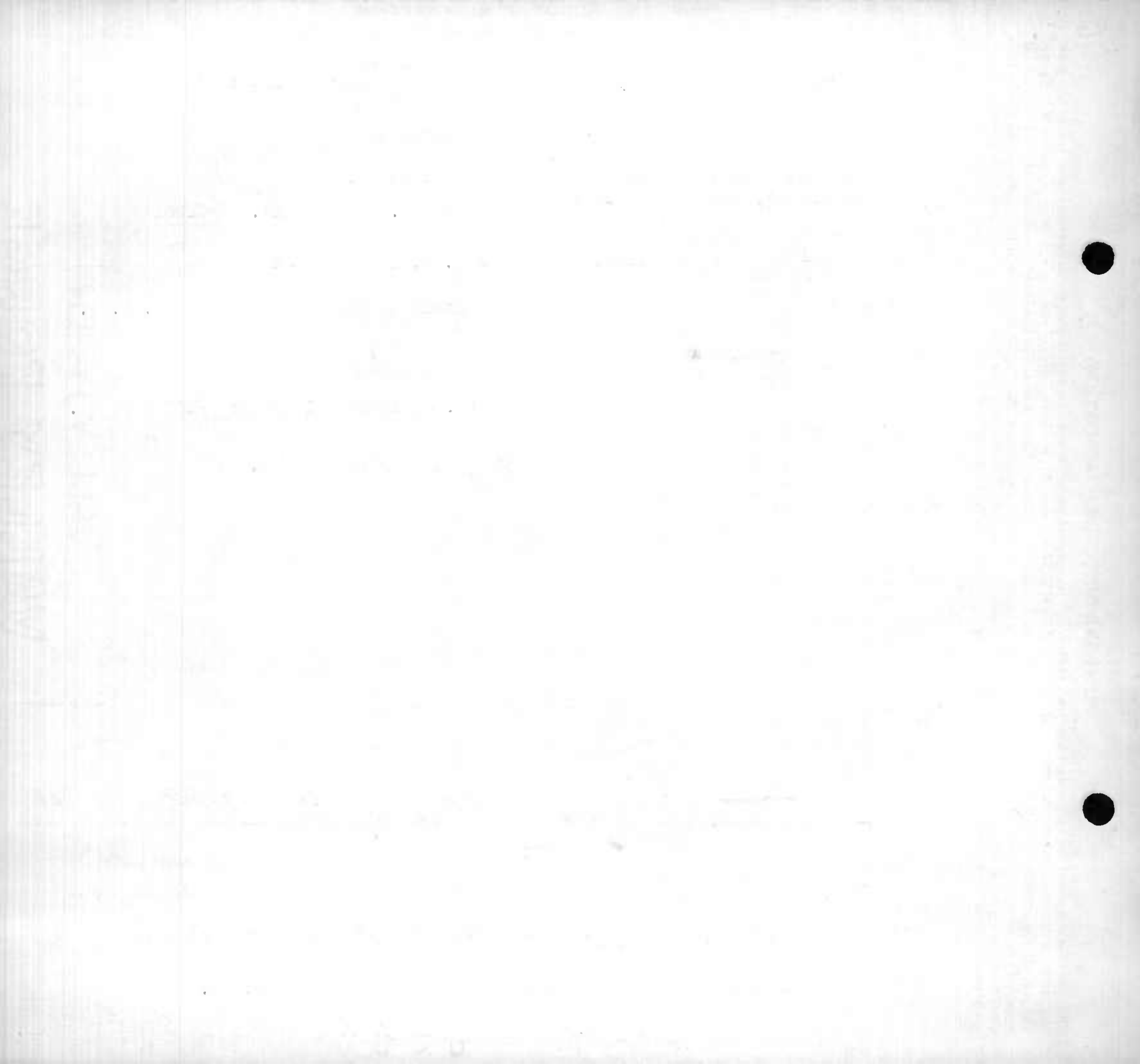
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 10343</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">66 10343</span>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Gatana</span> <span style="font-size: 1.2em;">Geppi</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 10, 1966</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">00</span> <span style="font-size: 1.2em;">530 West Mulberry Street</span> <span style="font-size: 1.2em;">Baltimore, Maryland 21201</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore,</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore,</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">530 W. Mulberry St. 21201</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Jan. 6, 1885</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Italy</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">? Tramontana</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>		
15. Was Deceased Ever in U. S. Armed Force? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">No</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Josephine DiStefano</span>
			ADDRESS <span style="font-size: 1.2em;">5109 York Rd.</span>		
18. <span style="font-size: 1.5em;">782.41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.5em;">Myocardial failure</span> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">10/1</span> 1966 to <span style="font-size: 1.2em;">10/10</span> 1966, that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">10/8</span> 1966 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Joseph R. Schick</span>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">10/12/66</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOSEPH R. ALBERTO</span>			23D. ADDRESS <span style="font-size: 1.2em;">3508 BANK ST. Baltimore Md.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">10/14/1966</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">New Cathedral Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 14 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">J. J. F. F. F.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wm. J. F. F. F.</span>	
				ADDRESS <span style="font-size: 1.2em;">Baltimore, Md.</span>	



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66 10344

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10344

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>JACK DONALD APPLE JR.</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 12, 1966 4:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>North Carolina</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Greensboro</b> D. STREET ADDRESS (If rural, give location) <b>2101 Cedar Fork Road</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>March 21, 49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>17</b>
13. FATHER'S NAME <b>Jack D. Apple</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Yakubowski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
		12. CITIZEN OF WHAT COUNTRY?	
		17. INFORMANT ADDRESS <b>Hanes-Lineberry F. H. Greensboro, N. C.</b>	

MEDICAL CERTIFICATION	18. CAUSE OF DEATH <b>E 8-16-4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Craniocerebral trauma</b> (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
	19A. DATE OF OPERATION <b>7</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
	21D. TIME OF INJURY (APPROX.) <b>October 8, 1966 2:30A</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Rt. 222 Intersection St. Marks Church</b>
	21F. HOW DID INJURY OCCUR? <b>Passenger in auto-auto collision</b>		
	22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
	ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>October 12, 1966</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		

23A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23B. DATE <b>10/14/1966</b>	23C. NAME of CEMETERY or CREMATORY <b>Greensboro, N. C.</b>	23D. LOCATION (City, town, or county) (State)
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 14 1966</b>	24B. NAME OF REGISTRAR <b>Robert E. Farley</b>	24C. FUNERAL DIRECTOR <b>Wm. J. Tidman &amp; Sons</b>	ADDRESS <b>Balto., Md. North Ave.</b>

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

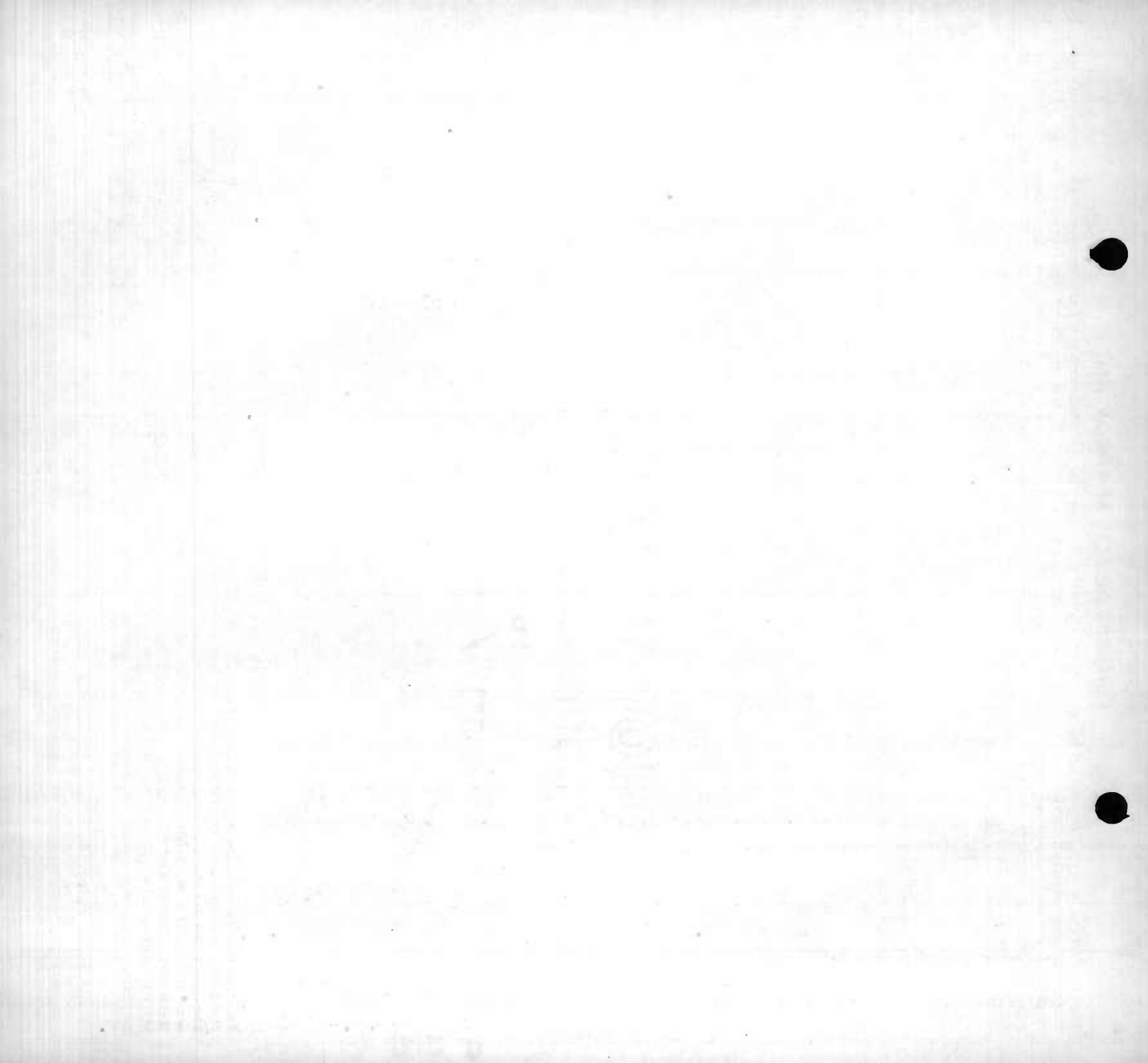
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10345 4	
BIRTH NO. 66 10345		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Laffoon</i>		2. DATE AND HOUR OF DEATH <i>10-12-66 11<sup>10</sup> A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>601</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>221 N. Kenwood Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>—</i>	8. DATE OF BIRTH <i>10/12/66</i>	9. AGE (in years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Blaney Laffoon</i>	14. MOTHER'S MAIDEN NAME <i>Rose Mary Burns</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Blaney Laffoon</i>	ADDRESS <i>221 N. Kenwood Ave</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Immaturity</i>		<i>3 hours</i>	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/12</i> 19 <i>66</i> to <i>10/12</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/12</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert R. Koltzhaus</i>		M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23B. DATE SIGNED <i>10/12/66</i>					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>	24B. DATE <i>10/13/66</i>	24C. NAME of CEMETERY or CREMATORY <i>New Bethel</i>	24D. LOCATION (City, town, or county) (State) <i>Edmondson Ave.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 14 1966</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	25C. FUNERAL DIRECTOR ADDRESS <i>Frederick D. Miller 3019 E. MONUMENT ST.</i>			

May

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <b>66 10346</b>	
BIRTH NO. <b>66 10346</b>				M.E. CASE NO. <b>66 10346</b>			
1. NAME OF DECEASED (Type or Print) <b>Bertha Wolz</b>				2. DATE AND HOUR OF DEATH <b>Oct. 12, 1966</b>   <b>7 30 p</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 4620 Coleherne Rd.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2804</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>4620 Coleherne Rd.</b>			
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-4-95</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Milke</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-28-2037</b>		17. INFORMANT <b>Richard P. Wolz</b>		ADDRESS <b>4620 Coleherne Rd.</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Cerebral hemorrhage</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hour</b>	
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/17</b> <b>1964</b> to <b>10/12</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Robert A. Reiter</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/13/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert A. Reiter</b>				23D. ADDRESS M.D. <b>606 Edmondson Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 14 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fajana</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. - 4101</b>		ADDRESS <b>Edmondson Av.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10347		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10347	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) John Nash			October 9, 1966 6:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital 1514 Division Street Baltimore, Maryland			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-03 D. STREET ADDRESS (If rural, give location) 2322 Division Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-19-09	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-20-7490	17. INFORMANT Hazel Nash		ADDRESS Same
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage (B) DUE TO Hypertension (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 9, 1966 to October 9, 1966, that (I) (we) last saw the deceased alive on October 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virgilio Javier			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 10, 1966
23C. PHYSICIAN'S NAME (Type) Dr. Virgilio Javier			23D. ADDRESS M.D. 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/14/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. OCT 14 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Address 1727 W. Mount	

THE NATIONAL ARCHIVES  
COLLECTION, BOSTON

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 10348		Registered No.	
BIRTH NO.		66 10348		CERTIFICATE OF DEATH		66 10348	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>MARY Black Shear Spell</i>				10/8/66 1 2 <sup>25</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lincoln Memorial Nursing Home</i>				A. STATE <i>md</i> B. COUNTY <i>X</i>			
27 N. Carey Street. <i>Baltimore, Md. 21223.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 11-04</i>			
D. STREET ADDRESS (If rural, give location) <i>443 Cummings Court.</i>							
5. SEX <i>F</i>	6. RACE <i>C</i>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>7/15/09</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Peter Spell</i>		14. MOTHER'S MAIDEN NAME <i>Alma Tell</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Grady Blackshear</i>		ADDRESS <i>443 Cummings</i>					
18. I <i>170X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Cancer of left Breast</i> DUE TO (B) <i>Metastasis.</i> DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 12</i> 19 <i>66</i> to <i>Oct 8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Oct 8</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I), (We), (did) (did not) view the body after death.							
23A. SIGNATURE <i>Thomas Sennardine</i> M.D.				23B. DATE SIGNED <i>10/8/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>Thomas Sennardine</i> M.D.				23D. ADDRESS <i>930 Whitelock St. Md. 17</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/13/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 14 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkema</i>		25C. FUNERAL DIRECTOR <i>A. S. Phillip</i>		ADDRESS <i>1727 N. Market</i>	

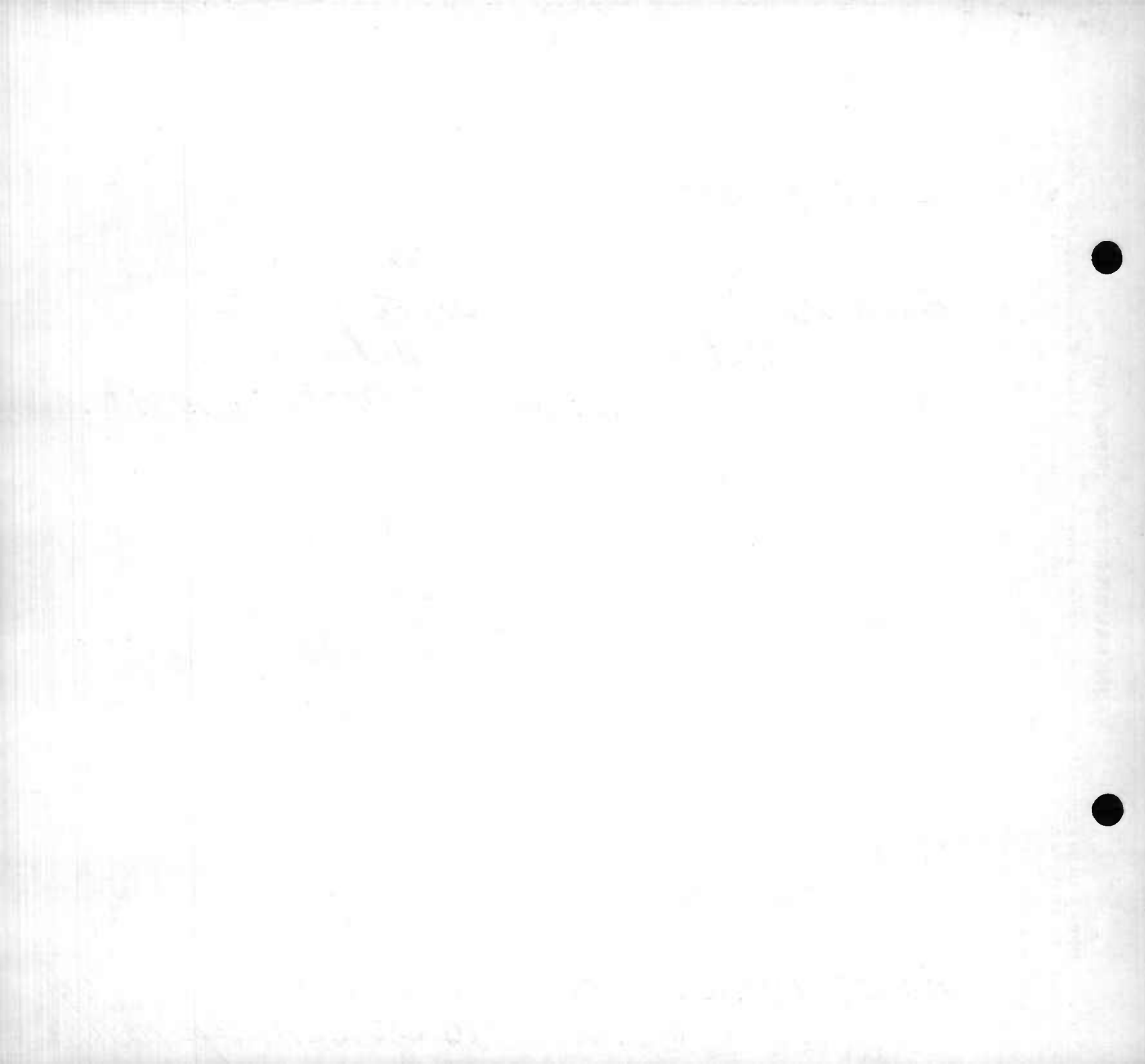
Wm. B. Ewing



# FUNERAL DIRECTOR: IMPORTANT

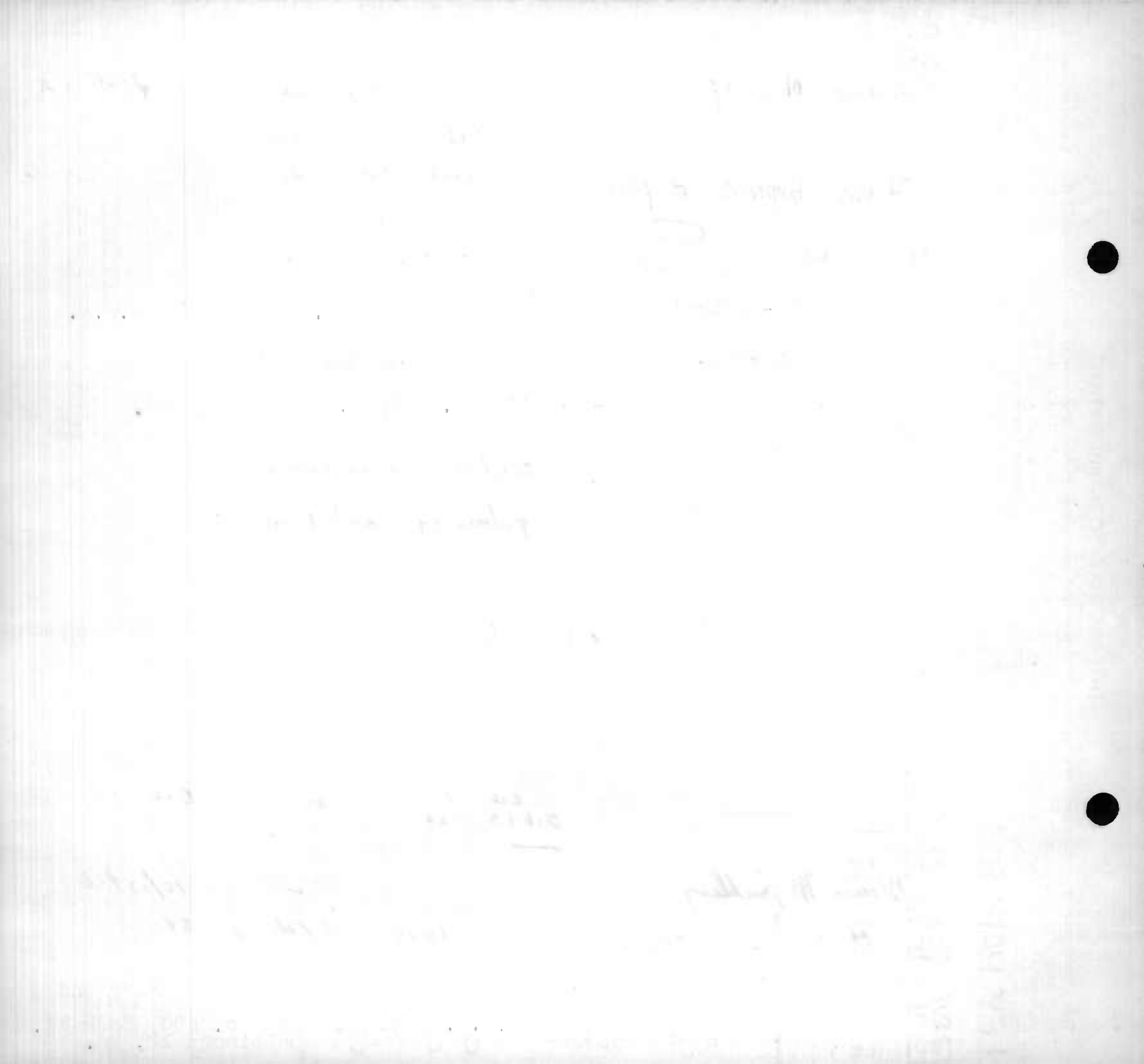
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 10349		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10349	
1. NAME OF DECEASED (Type or Print) <i>Alberta M. Bowie</i>				2. DATE AND HOUR OF DEATH <i>Oct. 10th 1966 9.50 A. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Sinai Hospital of Baltimore</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 15-04</i> D. STREET ADDRESS (If rural, give location) <i>2342 Reisterstown Rd.</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid.</i>		8. DATE OF BIRTH <i>7/4/16</i>	9. AGE (In years lost birthday) <i>50</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beautician</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-76-1814</i>		17. INFORMANT <i>Alvin McDaniel</i>		ADDRESS <i>1537 Smallwood St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>600.014-260X</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>				CAUSE OF DEATH (A) <i>Uremic syndrome</i> DUE TO (B) <i>Chronic pyelonephritis</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>5-6 years</i> <i>Un Known</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 1st 1966</i> to <i>Oct 10th 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct. 10th 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>William Cieplinski</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <i>10/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>William Cieplinski</i>				23D. ADDRESS <i>Sinai Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/13/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Ch. Baltimore</i>		24D. LOCATION (City, town, or county) (State) <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Walter C. Phillips</i>		ADDRESS <i>172 M. Manned</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

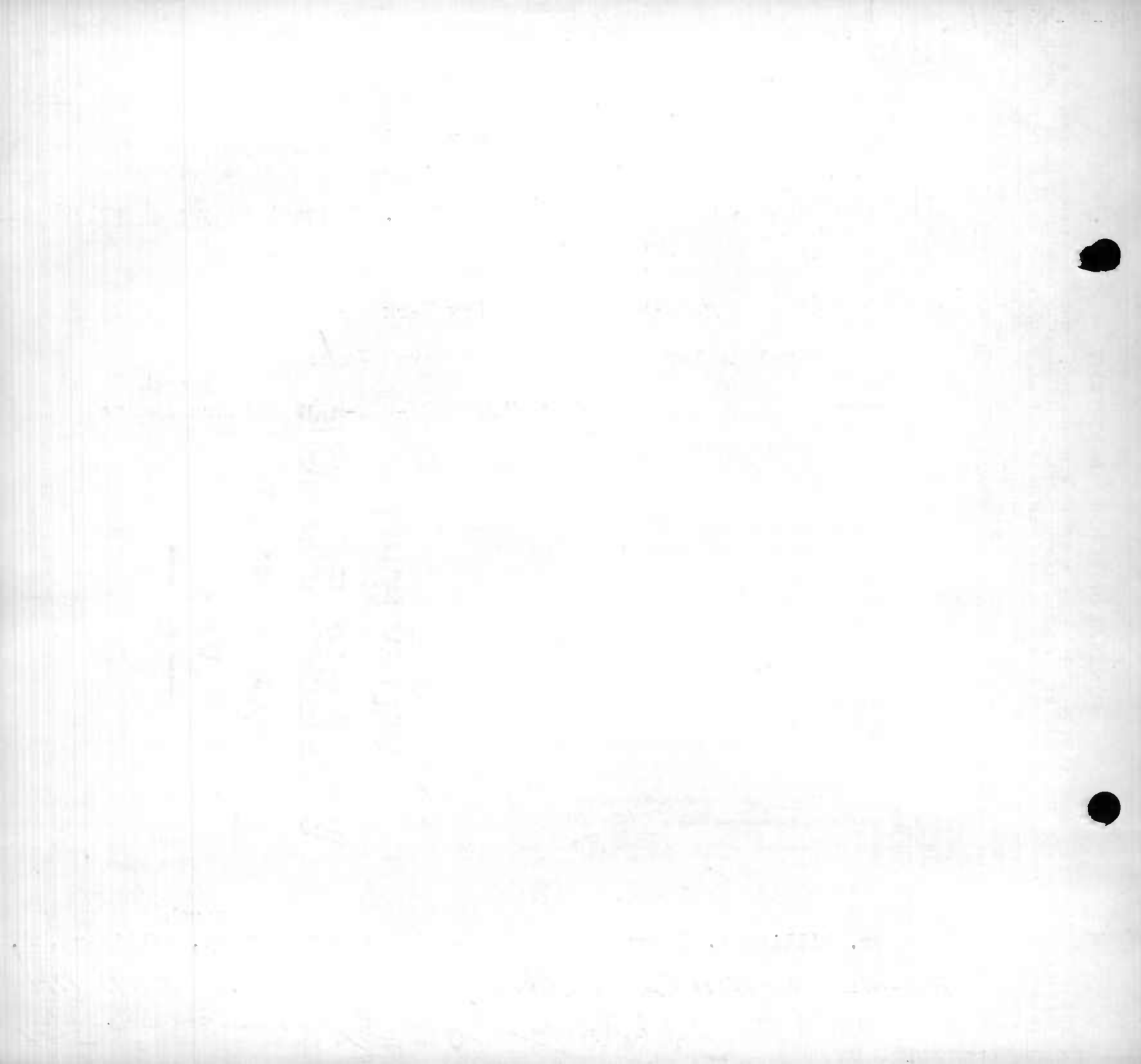
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 10350				
1. NAME OF DECEASED (Type or Print) <b>Alexander M. Knapp</b>					2. DATE AND HOUR OF DEATH <b>10/13/66 4:25 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 Johns Hopkins Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 12</b> D. STREET ADDRESS (If rural, give location) <b>12 Meadow Road</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED) (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4/25/07</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Life Insurance-Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Insurance Agency</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Alexander P. Knapp</b>			14. MOTHER'S MAIDEN NAME <b>Dorothy Maris</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>			16. SOCIAL SECURITY NO. <b>212-03-4371</b>		17. INFORMANT <b>Mrs. Betty R. Knapp</b>				
			ADDRESS <b>(Same)</b>						
18. <b>465X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>arteriosclerosis</b>					CAUSE OF DEATH (A) <b>cardiac arrhythmia</b> DUE TO (B) <b>pulmonary embolism</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1 1966</b> to <b>Oct 13 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct 13 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Monica M. Buckley</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/13/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Monica M. Buckley</b>			23D. ADDRESS <b>1620 McElderry St.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/15/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Oct 2, 1966</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10351</u>	
BIRTH NO. <u>K-400 66 10351</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>James Kelley</u>		2. DATE AND HOUR OF DEATH <u>10-14-66</u> <u>12<sup>22</sup> AM</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>26-08</u>			
D. STREET ADDRESS (If rural, give location) <u>3726 Mt. Pleasant Avenue</u> <u>#21224</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-7-78</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AMERICAN CAN.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Samuel Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah James</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>214-01-2521</u>		17. INFORMANT ADDRESS <u>#21224</u>	
18. <u>053.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <u>Pneumonia &amp; Sepsis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Arteriosclerotic Heart Disease</u> <u>5+ years</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-13-66</u> 19 <u>to</u> <u>10-14</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-14-</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William A. Emerson</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-14-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. William A. Emerson</u>		23D. ADDRESS <u>#21224</u> <u>BCH-4940 Eastern Avenue, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>Oct 17 1966</u>	24C. NAME OF CEMETERY or CREMATORY <u>BARLAWN CEM</u>		24D. LOCATION (City, town, or county) (State) <u>EASTERN AVE BALTO MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 14 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairman</u>		25C. FUNERAL DIRECTOR <u>Joseph J. Gannon</u> ADDRESS <u>265 S. Campbell</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10352				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10352	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GRACE PINKNEY				2. DATE AND HOUR OF DEATH OCT. 6, 1966 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38		(If not in hospital or institution, give street address or location)		A. STATE MD.		8. COUNTY	
5. SEX F		6. RACE N		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. CITY 15-B		D. STREET ADDRESS (If rural, give location) 438 PINLICO RD.	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated since 11/18/30		8. DATE OF BIRTH 3/18/30		9. AGE (In years last birthday) 36		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL PRYOR				14. MOTHER'S MAIDEN NAME ANNA SCOTT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHART University Hosp.		ADDRESS	
18. 600.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE TOXIC INFECTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Acute toxic infection (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 1/21 to present, that (we) last saw the deceased alive on OCT. 6 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gary D. Plotnick				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Oct 6, 1966	
23C. PHYSICIAN'S NAME (Type) Gary D. Plotnick				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-10-66		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cem		24D. LOCATION (City, town, or county) (State) A.A. Co Md	
25A. DATE REC'D BY HEALTH DEPT OCT 14 1966		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Rayner Sanders		ADDRESS 217 E Preston St	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10353		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10353	
1. NAME OF DECEASED (Type or Print) Margaret M. Meagher			2. DATE AND HOUR OF DEATH October 9, 1966		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pine Ridge Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2413 E. Oliver Street -21213		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Aug. 13, 1887	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? Maryland
13. FATHER'S NAME Patrick J. Meagher			14. MOTHER'S MAIDEN NAME Mary Leahy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-54-6345	17. INFORMANT William F. Meagher - 2413 E. Oliver Street		
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, apoplexy, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Arteriosclerotic Heart Disease Congestive failure (B) DUE TO Genit arteriosclerosis (C) Status Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 4 to Oct 9 1966 that (I) (we) lost saw the deceased alive on Oct 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DONALD W. MINTZER			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Oct 10 1966
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 10-12-66		
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT OCT 14 1966			25B. NAME OF REGISTRAR John E. Parker		
25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206			ADDRESS		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department		Baltimore City Health Department	
BIRTH NO. 66 10354				CERTIFICATE OF DEATH		Registered No. 66 10354	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>JOHN M. ANDERSON</u>			
2. DATE AND HOUR OF DEATH <u>10/12/66 7:00 A.M.</u>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL</u>				(If not in hospital or institution, give street address or location) <u>HOSP 48</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>2 HIS</u>			
D. STREET ADDRESS (If rural, give location) <u>1826 FAIRBANK RD</u>				5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>			
8. DATE OF BIRTH <u>8/31/00</u> 9. AGE (In years last birthday) <u>66</u>				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired from Penn. Railroad</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>W. Evans Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Elva Meredith</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>717-07-7467</u>			
17. INFORMANT <u>Catherine C. Anderson</u>				ADDRESS <u>same</u>			
18. <u>420.14-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Acute Myocardial infarction</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) <u>Diabetes mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				20. DATE OF OPERATION <u>9/21</u> 19 <u>66</u> to <u>10/12</u> 19 <u>66</u>			
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				22. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> 19 <u>66</u> to <u>10/12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u> M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>10/12/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				23D. ADDRESS <u>[Signature]</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>15 Oct 66</u>			
24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 14 1966</u>				25B. NAME OF REGISTRAR <u>[Signature]</u>			
25C. FUNERAL DIRECTOR <u>Burgee Funeral Home, 3631 Falls Road</u>				ADDRESS <u>[Signature]</u>			

11th March 1911

Dear Mr. [Name]  
I have the pleasure to inform you that your letter of the 10th inst. has been received.

I am sorry to hear that you are not well.

Yours faithfully,  
[Signature]

Enclosed find the [document]

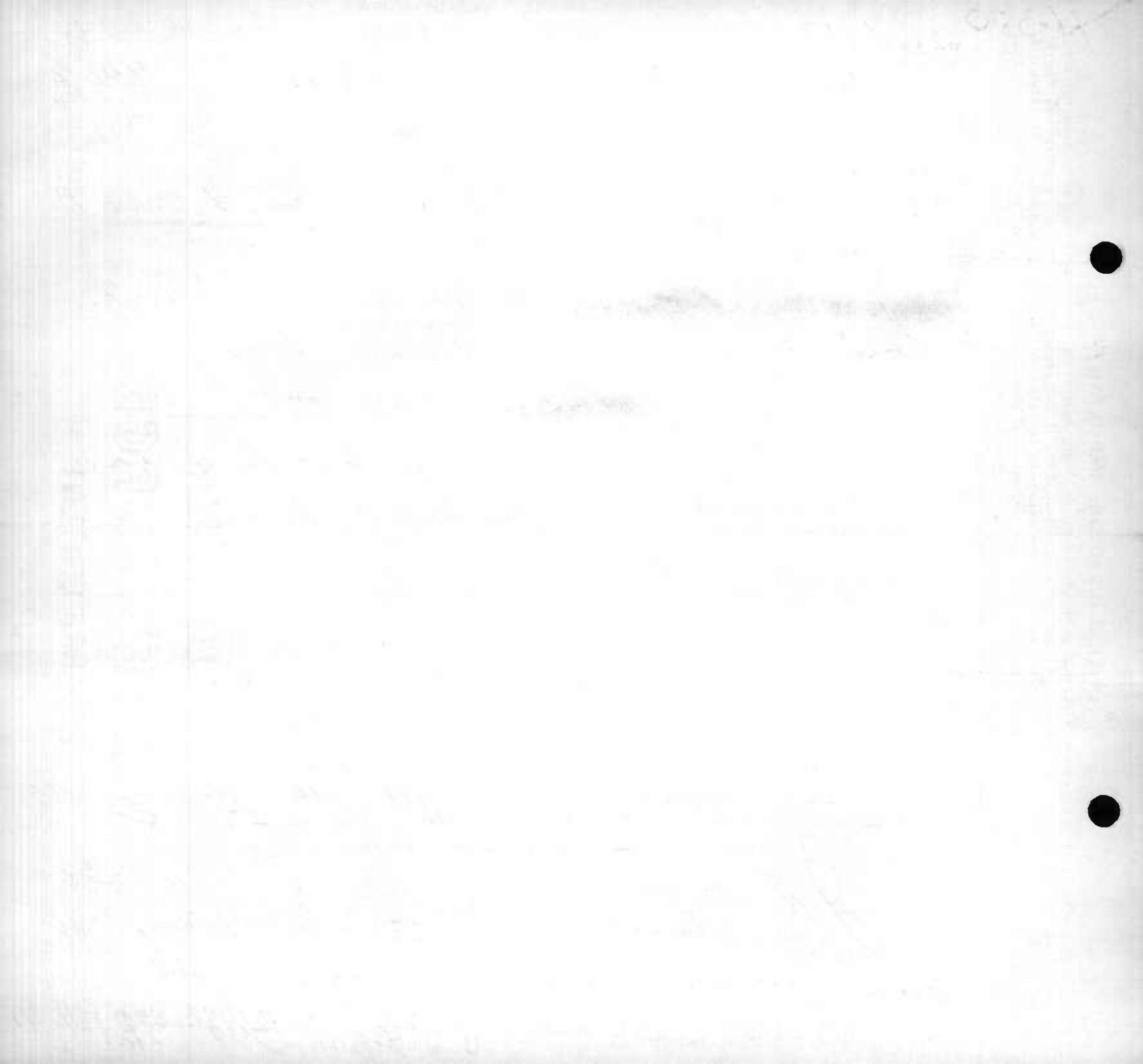
Yours truly,  
[Signature]

11th March 1911

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10355		CERTIFICATE OF DEATH		Registered No. 66 10355		
1. NAME OF DECEASED (Type or Print) <b>HAYDEN, RUTH MARIE</b>				2. DATE AND HOUR OF DEATH <b>10-13-66 6:50 A M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE UNION MEMORIAL HOSP</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-14</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>ROLAND PARK APTS. 6 UPLAND RD</b>						
5. SEX <b>F</b>	6. RACE <b>CAU</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-19-193</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator Apartment</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WESLEY TRAIL</b>			14. MOTHER'S MAIDEN NAME <b>VIRGINIA LEROY</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>214-14-2032</b>			17. INFORMANT <b>PATIENT'S CHART</b>				ADDRESS			
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE 5 DAYS</b>				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b>						
(C) DUE TO										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NONE</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? <b>NONE</b>		(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>NONE</b>		21F. HOW DID INJURY OCCUR? <b>NONE</b>						
22. I certify that <b>44</b> (this hospital) attended the deceased from <b>10-8-66</b> 19 <b>66</b> to <b>10-13-</b> 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>10-13</b> 19 <b>66</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.										
23A. SIGNATURE <b>Jeff Parker</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-13-66</b>				
23C. PHYSICIAN'S NAME (Type) <b>D5 Jeff Parker</b>				23D. ADDRESS M.D. <b>THE UNION MEMORIAL HOSP, BALT. MD.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>17 Oct. 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>LORRAINE PARK Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO Co. Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 14 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b>		ADDRESS <b>3631 Falls Rd</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10356		CERTIFICATE OF DEATH		Registered No. 66 10356	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>JESSE PHILLIP HAWKINS</b>				2. DATE AND HOUR OF DEATH <b>October 3 66 11:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>92 Maryland Penitentiary Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>					
				D. STREET ADDRESS (If rural, give location) <b>1727 Cliftview Ave., Baltimore, Maryland</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>8 May 1910</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Cairo, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Alexander Hawkins</b>				14. MOTHER'S MAIDEN NAME <b>Janie Nolan</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MD. Penitentiary Record</b>		ADDRESS		
18. <b>763 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Lung with metastases to brain and bone</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>14 Dec 65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Lung &amp; Brain</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NA</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>					
21D. TIME OF INJURY (APPROX.) <b>NA</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> <b>NA</b> While At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NA</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>June 1 1943</b> to <b>October 3 1966</b> , that (I) (we) last saw the deceased alive on <b>October 3 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Henry W.D. Holljes</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>October 3, 1966</b>			
23C. PHYSICIAN'S NAME (Type) <b>Henry W.D. Holljes</b>		23D. ADDRESS <b>954 Forrest Street, Baltimore, Maryland</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-11-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Em. A. A. Co.</b>		24D. LOCATION (City, town, or county) (State) <b>md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 14 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Rayner Sanders</b>		ADDRESS <b>217 C Preston St</b>			



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66 10357

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 10357

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PEARL

M.

ULRICK

2. DATE AND HOUR PRONOUNCED DEAD

October 12, 1966

12:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Pennsylvania

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Philadelphia

D. STREET ADDRESS (If rural, give location)

9316 Treaty Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

August 10, 1911

9. AGE (In years  
last birthday)

55 55

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-----

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Lucas

14. MOTHER'S MAIDEN NAME

Mary ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

202-05-5538

17. INFORMANT

ADDRESS

William M. Ulrick 9316 Treaty Rd. Phil. Pa

18.

E8571X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Septicemia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Extensive Body Burns.  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Boat

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Middle River, Baltimore County

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
9 11 '66 P

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Explosion aboard 30' Owens Cruiser

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/13/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/17/66

23C. NAME OF CEMETERY or CREMATORY

Resurrection Cemetery

23D. LOCATION

(City, town, or county)

Hulmeville Pennsylvania

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 14 1966

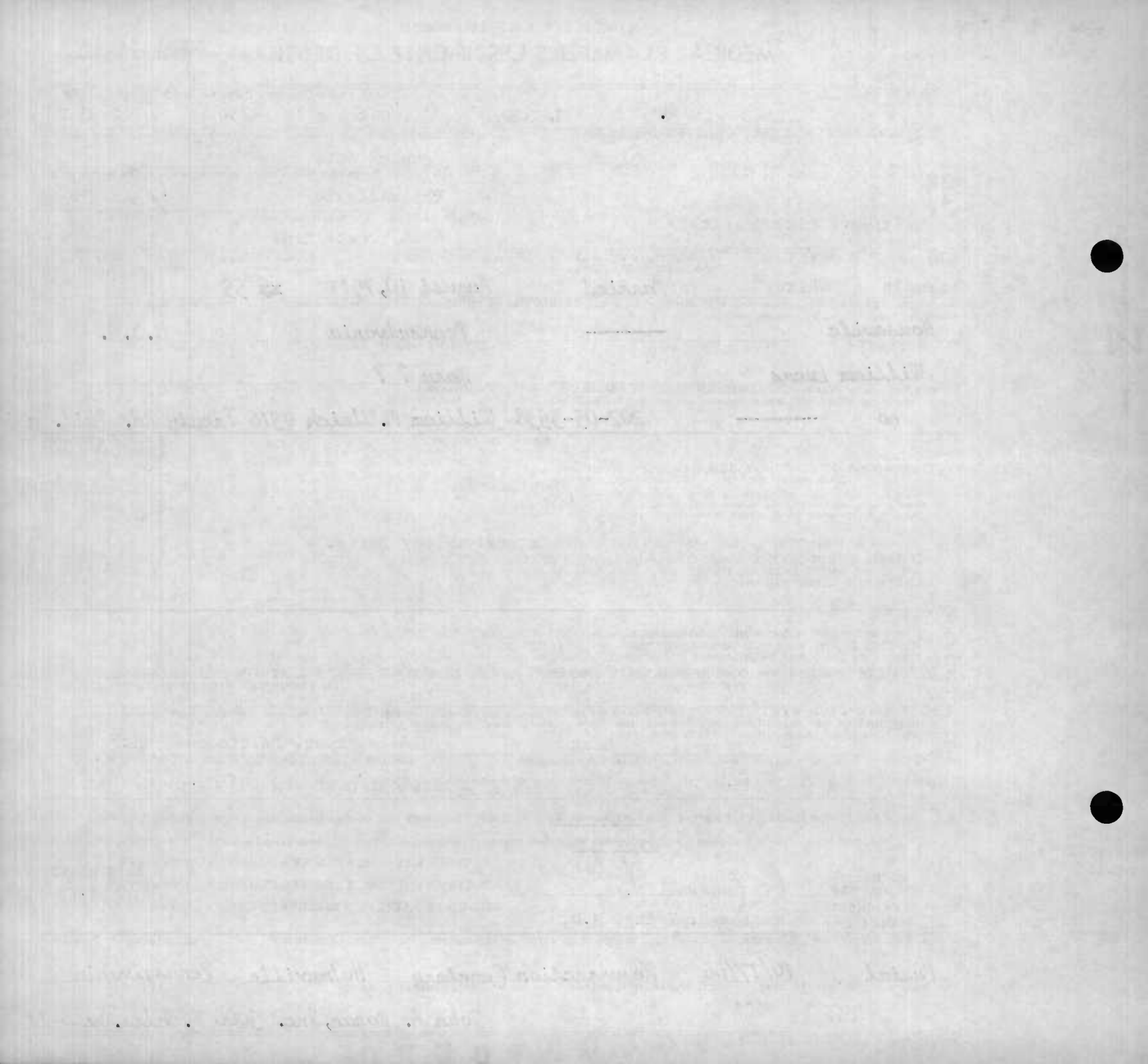
24B. NAME OF REGISTRAR

John A. Moran, Inc.

24C. FUNERAL DIRECTOR

3000 E. Balto. St Balt

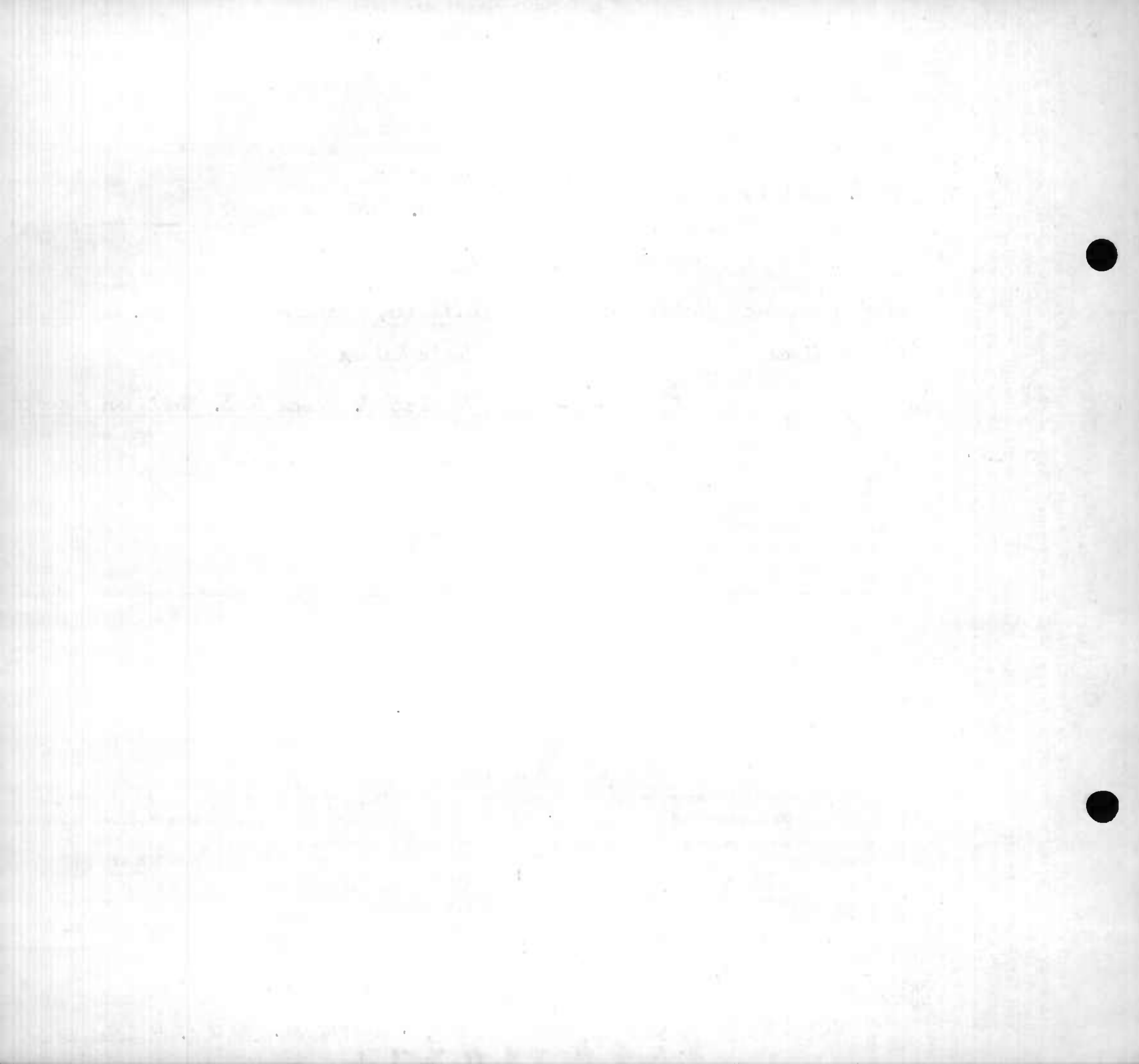
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10358				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10358	
M.E. CASE NO. 66 10358				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>John Louis Wiser</i>				2. DATE AND HOUR OF DEATH <i>October 12, 1966</i> 11:50 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>10 S. Robinson Street</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>10 S. Robinson Street</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>2/21/1898</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Deisel Operator</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Weiskettel</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>William Wiser</i>				14. MOTHER'S MAIDEN NAME <i>Annie Kaiser</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-3797A</i>		17. INFORMANT ADDRESS <i>Elizabeth M. Wiser 10 S. Robinson Street</i>			
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Cerebral Vascular Accident</i> DUE TO (B) <i>Generalized atherosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>10/10/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/10/66</i> to <i>10/12/66</i> , that (I) (we) last saw the deceased alive on <i>10/10/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Julius H. Goodman</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/13/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Julius H. Goodman M.D.</i>		23D. ADDRESS <i>3460 E. BALTIMORE ST.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/15/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Mausoleum</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 14 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Baltimore St.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10359		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10359	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Perry Wright</b>		2. DATE AND HOUR OF DEATH <b>Oct. 9, 1966</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2326 Mosher Street</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>16-05</b>	
D. STREET ADDRESS (If rural, give location) <b>2326 Mosher Street</b>		5. SEX <b>Male</b>		6. RACE <b>Colored</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Oct. 21, 1880</b>		9. AGE (In years lost birthday) <b>85</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George Wright</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Wilson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-07-0310</b>		17. INFORMANT <b>Rebecca Gaither</b> ADDRESS <b>2326 Mosher St.</b>	
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>ASHD C Cong. Frick. 6 yrs.</b> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 1956</b> to <b>10/9</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>10/6</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>J. Preston Grant</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/13/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Preston Grant</b>		23D. ADDRESS <b>601 N. Cranston</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 13, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Westport (Baltimore) Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 14 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Joseph L. Russ</b>		ADDRESS <b>2222 W. North Ave. Baltimore, Md.</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10360</u>	
BIRTH NO. <u>66 10360</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARGARET GRAFF FISHER JESSOP</u>		2. DATE AND HOUR OF DEATH <u>OCT. 13, 1966</u>   <u>7:05 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>503 S. HULTON AVE</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>503 S. HULTON AVE</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 19, 1916</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PACKAGING</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CANNING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GRAFF</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-09-4183</u>		17. INFORMANT <u>ELMER JESSOP, JR.</u>	
18. <u>141.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma Tongue</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Severe malnutrition</u>		4 mos	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>66</u> to <u>Oct</u> 19 <u>66</u> , that (I) <del>was</del> last saw the deceased alive on <u>11 Oct</u> 19 <u>66</u> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <u>H.H. Baylus</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>14 Oct 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>H.H. BAYLUS</u>		23D. ADDRESS <u>1600 Wellens Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-17-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>WESTERN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Faldema</u>		25C. FUNERAL DIRECTOR <u>Geo. L. Schwab</u> <u>Funeral Home</u> <u>Francis H. Miller</u> <u>2101 Frederick Ave.</u>			

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66 10361

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 10361

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) PRUDELLA		2. DATE AND HOUR PRONOUNCED DEAD October 14, 1966 6:40 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secour Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-03 D. STREET ADDRESS (If rural, give location) 1920 Lemmon Street	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 3, 1883
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic	9. AGE (In years last birthday) 82
11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC Whitlock		14. MOTHER'S MAIDEN NAME Lydia Hickocks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 217-54-4408	
17. INFORMANT EARL NUTTING		ADDRESS 447 S. Stricker St.	
18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 10-18-66	
23C. NAME OF CEMETERY or CREMATORY BALTIMORE National		23D. LOCATION (City, town, or county) (State) BALTIMORE Md.	
24A. DATE REC'D BY HEALTH DEPT. OCT 17 1966		24B. NAME OF REGISTRAR Robert E. Farkas	
24C. FUNERAL DIRECTOR		24D. ADDRESS	
GEO. L. Schwab		Funeral Home	
Francis W. Miller		2101 Frederick Ave.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10362				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10362	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Melvin Evans				10/13/66 4:10pm			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
South Baltimore General Hospital				1148 Riverside Ave			
43 Baltimore, Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				Baltimore 30, Maryland 21230			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
male	white	never married	12/19/46	19			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
waterman		Seafood		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Father/Whitt/ Weldon W. Evans				Edna Marshall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no None				Mrs. Edna M. Evans, same as 4. ABCD above		short Whitt,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
II				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				2 weeks			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				7 weeks			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2 None				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (H) (this hospital) attended the deceased from 9-21 1966 to 10-13 1966, that (H) (we) last saw the deceased alive on 10-13- 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		10/13/66	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/16/66		Tylerton Cemetery		Tylerton, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 17 1966		R. E. F. Evans		Bradshaw & Sons, Crisfield, Maryland			

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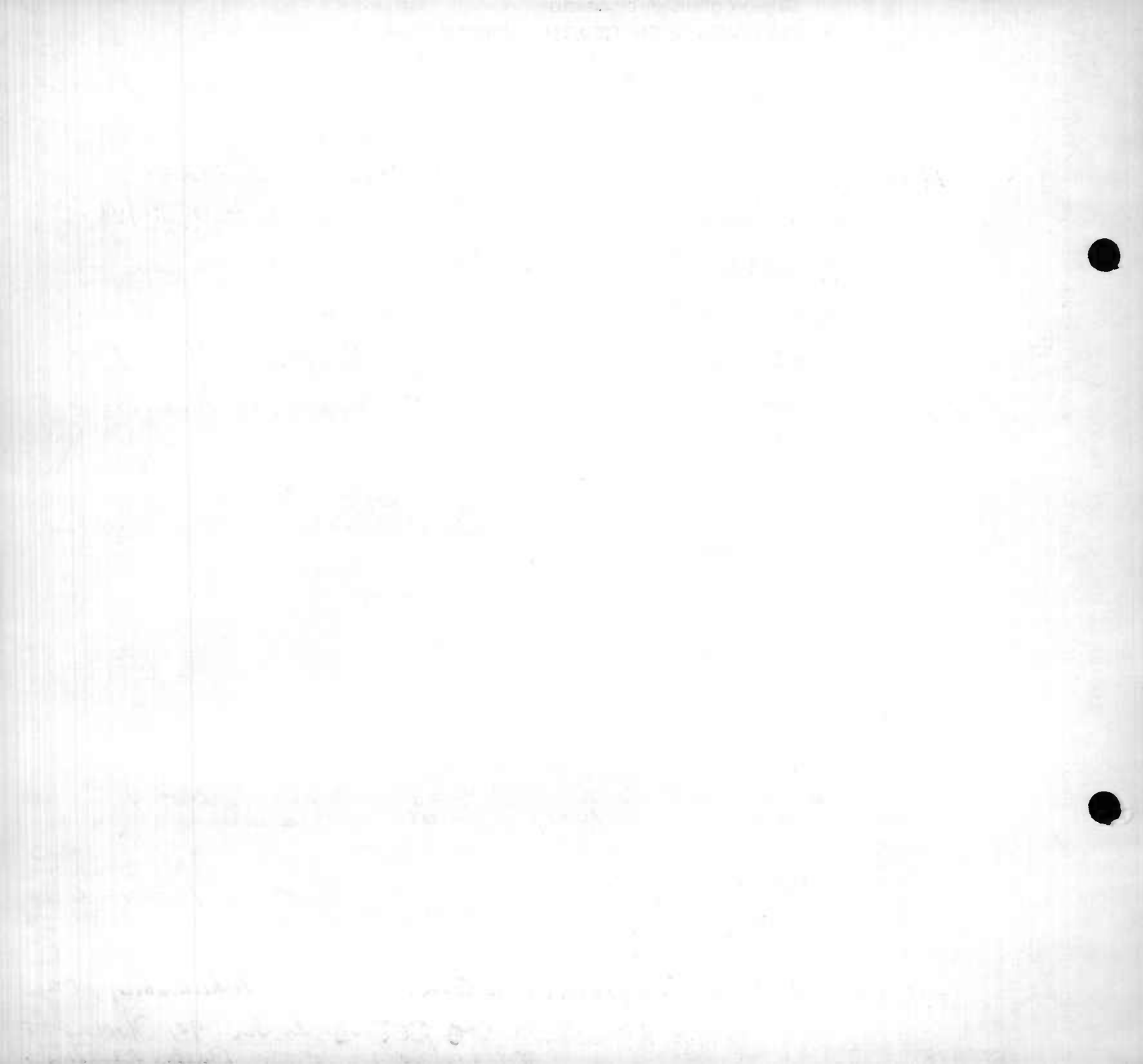
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10363</b>	
BIRTH NO. <b>66 10363</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>Frances Boggs</b>		2. DATE AND HOUR OF DEATH <b>10-14-1966 7:00 A.M.</b>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hosp.</b>		A. STATE <b>Maryland</b> B. COUNTY <b>2202</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #21230</b>			
5. SEX <b>F.</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Divorced</b>	
8. DATE OF BIRTH <b>11-20-1920</b>		9. AGE (In years last birthday) <b>45</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Burt Gammon</b>		14. MOTHER'S MAIDEN NAME <b>Norma Hurst</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Larry E. Boggs - 646 Washington Blvd</b>	
18. <b>420.1 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		Immediate	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Myocardial Infarction		Years	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ASCVDs			
II		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>this</del> (this hospital) attended the deceased from <b>9-28</b> 19 <b>66</b> to <b>10-14</b> 19 <b>66</b> , that <del>we</del> (we) last saw the deceased alive on <b>10-14</b> 19 <b>66</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Abouy</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-14-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. Abouy</b>		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/18/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Old Wheelersburg Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Wheelersburg, Ohio</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>2800 Broadview Ln. Inc. 901 Hallway St. Balt. 23, Md.</b>			



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66 10364

BALTIMORE CITY HEALTH DEPARTMENT

66 10364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CECELIA A. CARROLL

2. DATE AND HOUR PRONOUNCED DEAD

October 14, 1966 7:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 205 Beechfield Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

205 S. Beechfield Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 29, 1899

9. AGE (In years  
(last birthday))

66 67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph F. Neville

14. MOTHER'S MAIDEN NAME

Rose Bonhage

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Balto. Md.  
Mr. Bernard F. Carroll 205 S. Beechfield Ave.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/14/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct. 17, 1966

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 17 1966

G. Truman Schwab 3512 Frederick Ave. Balto.



VALLEY FORD



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66 10365

BALTIMORE CITY HEALTH DEPARTMENT

66 10365

BIRTH NO. *Balto Co. Md* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT JOSEPH SCHARFER, JR.</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 10, 1966 10:02 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b> <b>33</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2520 McElderry Street</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>---</b>	8. DATE OF BIRTH <b>9-3-66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ROBERT J. SCHARFER, SR.</b>	
14. MOTHER'S MAIDEN NAME <b>SYLVIA D. SPONAGLE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>---</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT ADDRESS <b>Mrs. Sylvia D. Schaffer - 2520 McElderry St.</b>	
18. CAUSE OF DEATH <b>493X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>---</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>---</b>
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>---</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>---</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>---</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>---</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Rudiger Breitenecker, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/11/66</b>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>10-14-66</b>	
23C. NAME OF CEMETERY or CREMATORY <b>BALTO. NATIONAL CEM.</b>		23D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
24C. FUNERAL DIRECTOR <b>Harley Miller - 2334 Jefferson St.</b>		24D. ADDRESS <b>---</b>	

WALSH & POLICE

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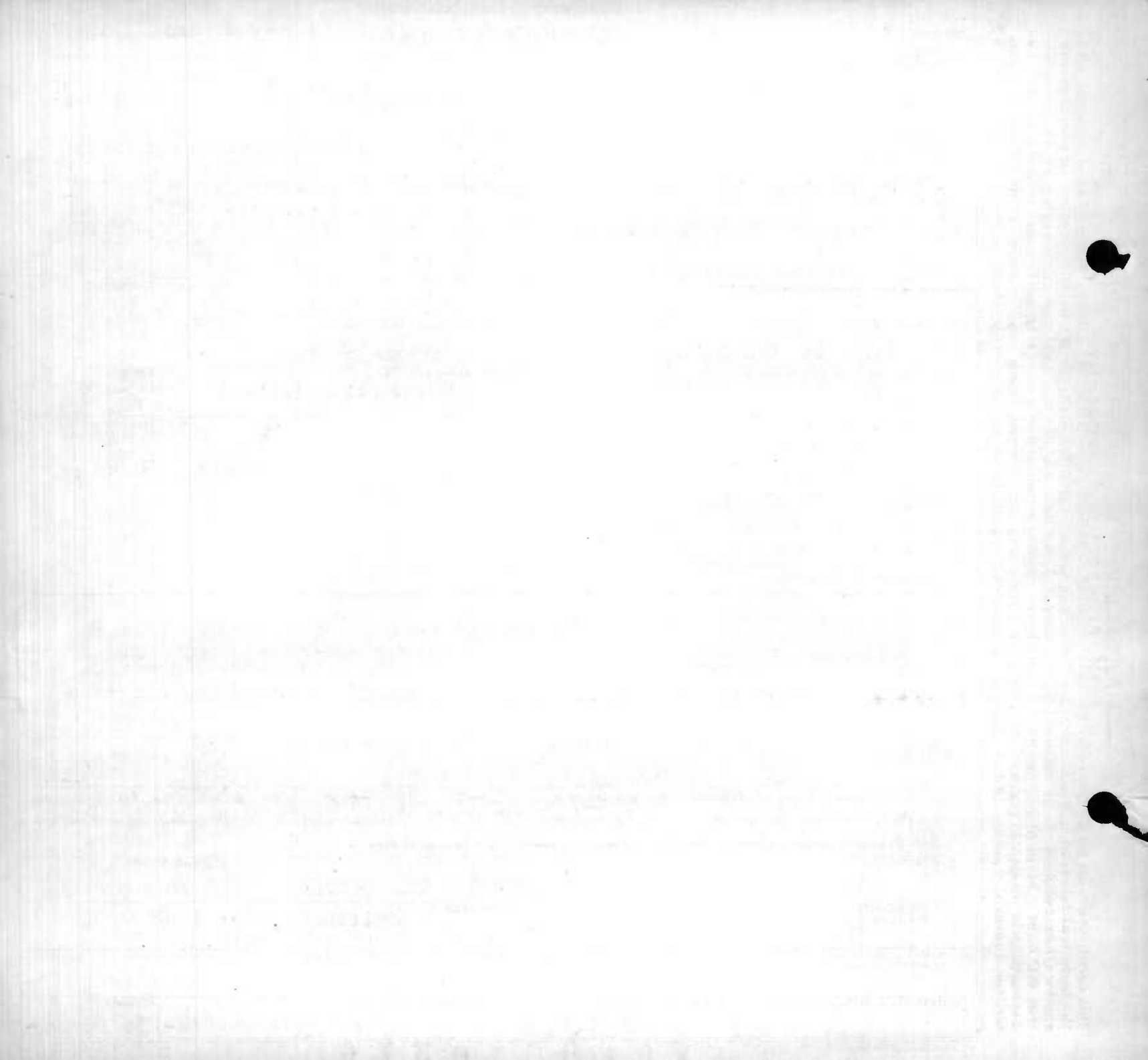
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 10366		CERTIFICATE OF DEATH		66 10366	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Louisa J. Holtzoff			10-14-66 12:35 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
The Gundry Sanitarium Inc 90			Md 28-04		
5. SEX			6. CITY OR TOWN (If outside city limits, write RURAL and give township)		
F W			Baltimore		
7. MARIED, NEVER-MARRIED WIDOWED, DIVORCED (specify)			D. STREET ADDRESS (If rural, give location)		
			2 N. Wickham Rd		
8. DATE OF BIRTH			9. AGE (In years last birthday)		
7-26-1893			73		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
			New York		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Wm. J. Cowan			Louisa J. -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			none		
17. INFORMANT			ADDRESS		
Alexander Holtzoff			Broadwood Apts Unit 3601 Connetquot Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
434.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			2 days -		
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Years		
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Sept. 19 1966 to October 14 1966, that (I) (we) last saw the deceased alive on October 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Rachel K. Gundry M.D.			10-14-66		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Rachel K. Gundry M.D.			Baltimore, Maryland The Gundry Sanitarium, Inc.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/17/66		New Cathedral Cemetery Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
				Sterling Funeral Estate-736 Edmondson Avenue	
25C. FUNERAL DIRECTOR		25D. ADDRESS			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 534		66 10367		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 10367	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) HANDLER, JOHN, M.				2. DATE AND HOUR OF DEATH 10/13/66 1:15AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY		M. BALTS CO.	
31 B.C.H.		4940 Eastern Avenue, Baltimore, Maryland		C. CITY OR TOWN BALT, MD.		(If outside city limits, write RURAL and give township)		21221 53-00	
D. STREET ADDRESS (If rural, give location)				311 Candy Terr					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED		8. DATE OF BIRTH 1/22/98		9. AGE (In years last birthday) 68		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME WM. HANDLER				14. MOTHER'S MAIDEN NAME MARY ROTHROCK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-12-5573-A		17. INFORMANT Records: BCM-4940 Eastern Avenue		ADDRESS 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I ACUTE MYOCARDIAL INFARCTION				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10/11 1966 to 10/13 1966, that (I) (we) last saw the deceased alive on 10/13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Allen Ginsberg				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/13/66			
23C. PHYSICIAN'S NAME (Type) ALLEN GINSBERG				23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/15/66		24C. NAME OF CEMETERY or CREMATORY LOUDEL PARK		24D. LOCATION (City, town, or county) (State) BALTO MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR J. E. F. J. J.		25C. FUNERAL DIRECTOR Connelly Son		ADDRESS 300 Mac			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10368</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <span style="font-size: 1.5em;">66 10368</span></p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Catherine Krahn</span></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 13-1966</span> <span style="float: right;">6:16 P.M.</span></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 1.5em;">90</p> <p style="font-size: 1.2em;">Gould Convalesarium 6116 Belair Rd. Balto. Md.</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Dundalk</span> <span style="float: right;">3300</span></p> <p>D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1718 Brookview Road, 21222</span></p>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6-29-1888</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">78</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Charles Kraning</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Henkleman</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-09-1862-B</span>			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Husband, Mr. Henry Krahn, # 4, a, b, c, d.</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">443X1</span>			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<p>(A) <span style="font-size: 1.2em;">Cerebrovascular accident</span> <span style="float: right;">2 days</span></p> <p>(B) <span style="font-size: 1.2em;">Probable Thrombosis due to advanced A.S.C.V.</span> <span style="float: right;">years</span></p> <p>(C) <span style="font-size: 1.2em;">with chronic fibrillation</span> <span style="float: right;">years</span></p> <p><span style="font-size: 1.2em;">Essential Hypertension</span> <span style="float: right;">years</span></p>		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <span style="font-size: 1.2em;">Dec - 19 66</span> to <span style="font-size: 1.2em;">Oct 13 19 66</span>, that (I) (<del>we</del>) last saw the deceased alive on <span style="font-size: 1.2em;">Oct 13 19 66</span> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above, (I) (<del>we</del>) (<del>did not</del>) view the body after death.</p>					
23A. SIGNATURE <span style="font-size: 1.5em;">Ataollah Golpira</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">Oct. 14-1966</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Ataollah Golpira M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">1942 Cedar Lane, Dundalk, Md. 21222</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">Oct. 17-1966</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Meadowridge Memorial</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Dorsey, Md.</span>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Orelab E. Talone</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">JOHN J. DUDA, Dundalk, Md. 21222</span>			



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 10369		ELsie P. WATSON		66 10369	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Elsie P. Watson		Oct. 15, 1966		5:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland General Hospital		Maryland Baltimore		Balt. Co.	
48		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		53.00	
		D. STREET ADDRESS (If rural, give location)			
		7352 Geise Ave		21219	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
Female	White	Married	2/5/05	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Kurt Shiflett		Icy Shiflett		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Audrey Konarski 7349 Geise Avenue, Jones Creek, Maryland 212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X I		Broncho pneumonia, BILATERAL		10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Coronary Thrombosis probab. 1 hr.			
		(C) Diabetes mellitus - known 3-4 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Oct. 11, 1966 to Oct. 15, 1966, that (I) (we) last saw the deceased alive on Oct. 15, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
W. Michael Gould				10/15/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
W. Michael Gould		Md. General Hospital, Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Oct-18-1966		Oak Lawn	
				Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				JOHN J. DUDA, Dundalk, Maryland 21222	

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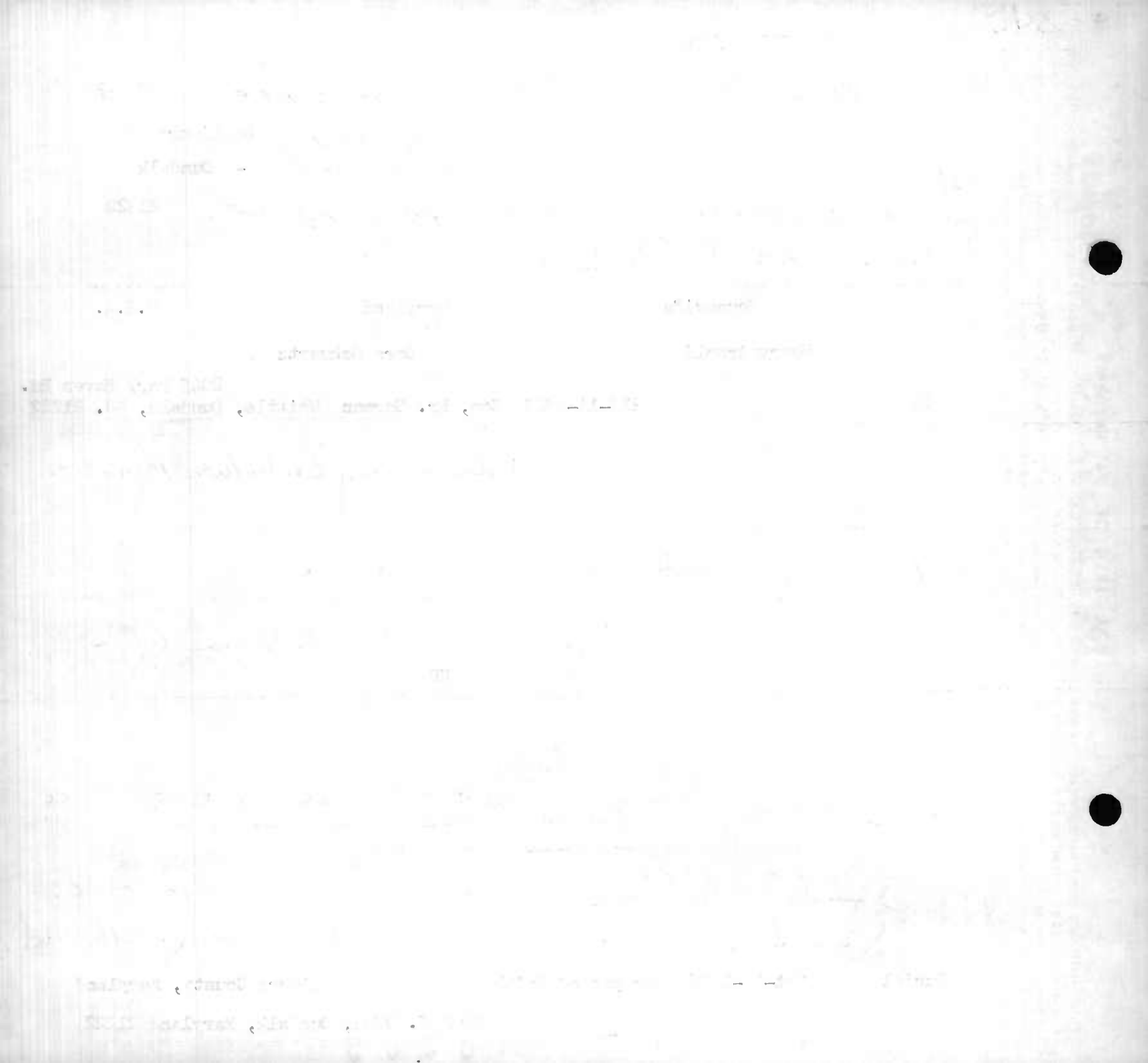
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10370</u>
BIRTH NO. <u>66 10370</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		NAME OF DECEASED (Type or Print) <u>WHITTLE DOROTHY</u>		DATE AND HOUR OF DEATH <u>10/15/66</u> <u>3:31 P. M.</u>
PLACE OF DEATH IN BALTIMORE, MARYLAND		USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42</u> <u>SINAI HOSPITAL OF BALTO</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> - <u>Dundalk</u> <u>53-00</u>		
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>1949 CODD AVE.</u> <u>21222</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. <del>MARRIED</del> NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-6-03</u>	9. AGE (In years last birthday) <u>62</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Dora Schwartz</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-9842</u>		17. INFORMANT <u>Son, Mr. Gorman Whittle, Dundalk, Md. 21222</u>
18. <u>465X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Pulmonary Embolus</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u> <u>Hypertensive Cardiovascular Disease</u> <u>years</u>				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>Sept 5</u> 19 <u>66</u> to <u>Oct 15</u> 19 <u>66</u> , that (1) <u>we</u> last saw the deceased alive on <u>Oct 14</u> 19 <u>66</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did) <u>(did not)</u> view the body after death.				
23A. SIGNATURE <u>David I. Miller</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10-15-66</u>		
23C. PHYSICIAN'S NAME (Type) <u>David I. Miller</u> M.D.		23D. ADDRESS <u>Lisbon Rd. Owings Mills, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct-19-1966</u>	24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1966</u>	25B. NAME OF REGISTRAR <u>John J. Duda</u>	25C. FUNERAL DIRECTOR ADDRESS <u>JOHN J. DUDA, Dundalk, Maryland 21222</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 10371</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 10371</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ELIZABETH ARRIGO</b>			2. DATE AND HOUR OF DEATH <b>10-14-1966 3:30AM.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME AND HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE CITY</b> D. STREET ADDRESS (If rural, give location) <b>1443 PATAPSCO AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>12-20-'01</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HERBERT PARKS</b>			14. MOTHER'S MAIDEN NAME <b>LULA BULL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-28-2178</b>	17. INFORMANT <b>BERNICE HEDRICK</b> ADDRESS <b>Baltimore, Md. RT. 10 BOX 74C (19)</b>		
18. <b>199.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA, METASTATIC</b> INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 4 1966</b> to <b>OCTOBER 14 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT 13 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. C. MARIANO</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-14-66</b>
23C. PHYSICIAN'S NAME (Type) <b>J. C. MARIANO</b>			23D. ADDRESS <b>CHURCH HOME &amp; HOSP. BALTIMORE, MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/17/66</b>	24C. NAME of CEMETERY or CREMATORY <b>Parksley Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Parksley, Maryland</b>	
25A. DATE REC'D <b>OCT 17 1966</b>		25B. NAME of REGISTRAR <b>John E. Taylor, Md.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>	

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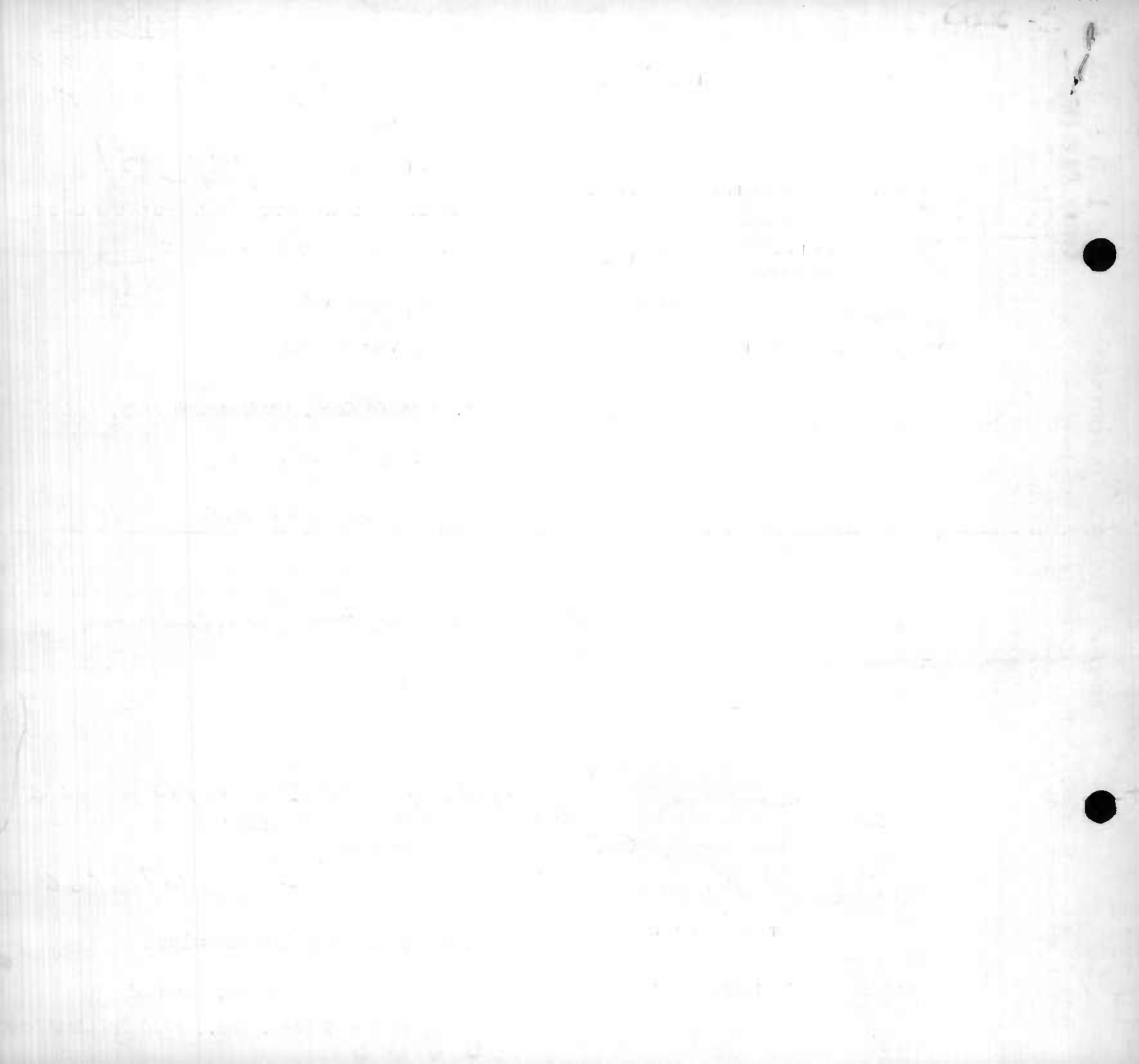
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10372	
BIRTH NO. 66 10372		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PAULINE S. COOK		2. DATE AND HOUR OF DEATH 10/13/66 @ 7:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY MARYLAND			
THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
33		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		MARLBOROUGH APTS 1701 EUTAW PLACE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 03-14-89	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Belair, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACOB SCHAPIRO		14. MOTHER'S MAIDEN NAME BERTHA Seaman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Terrold Cook, Marlborough Apts, Apt 2G	
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Myocardial infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Coronary atherosclerosis			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Atrial fibrillation, atherosclerosis			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/29 1966 to 10/13 1966, that (I) (we) last saw the deceased alive on 10/13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Peter J. Rosen M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10/13/66	
23C. PHYSICIAN'S NAME (Type) PETER ROSEN M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/16/66		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Sol. Levinson & Bros. Inc., 6010 Reisterstown	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR ADDRESS	
24J. DATE REC'D BY HEALTH DEPT.		24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <b>66 10373</b>	
<b>FILE NO.</b> 66 10373 <b>M.E. CASE NO.</b>				<b>1. NAME OF DECEASED</b> (Type or Print) <b>GOLDMAN, ABRAHAM</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>10-13-66 11:47 M.</b>	
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSP.</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4921 QUEENSBERRY AVE.</b>			
<b>5. SEX</b> <b>M</b>	<b>6. RACE</b> <b>W</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <b>WIDOWED</b>		<b>9. AGE</b> (In years lost birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>SHOE REPAIRER</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>POLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>UNKNOWN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>UNKNOWN</b>		<b>17. INFORMANT</b> <b>MRS. MARY CAPLAN 4767 Byron Road</b>			
<b>18. CAUSE OF DEATH</b> <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO <b>ASCVD.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 DAYS.</b>
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>—</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>NO</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY (APPROX.)</b> <b>—</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from 10-7-66 to 10-13-1966, that (I) (we) last saw the deceased alive on 10-13-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <b>Alvin Schachter</b> M.D.				<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>10-13-66.</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>ALVIN SCHACHTER.</b> M.D.				<b>23D. ADDRESS</b> <b>SINAI HOSPITAL.</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>10/14/66</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Rudomer Verein</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Sol. Levinson &amp; Bros. Inc., 6010 Reisterstown</b>			

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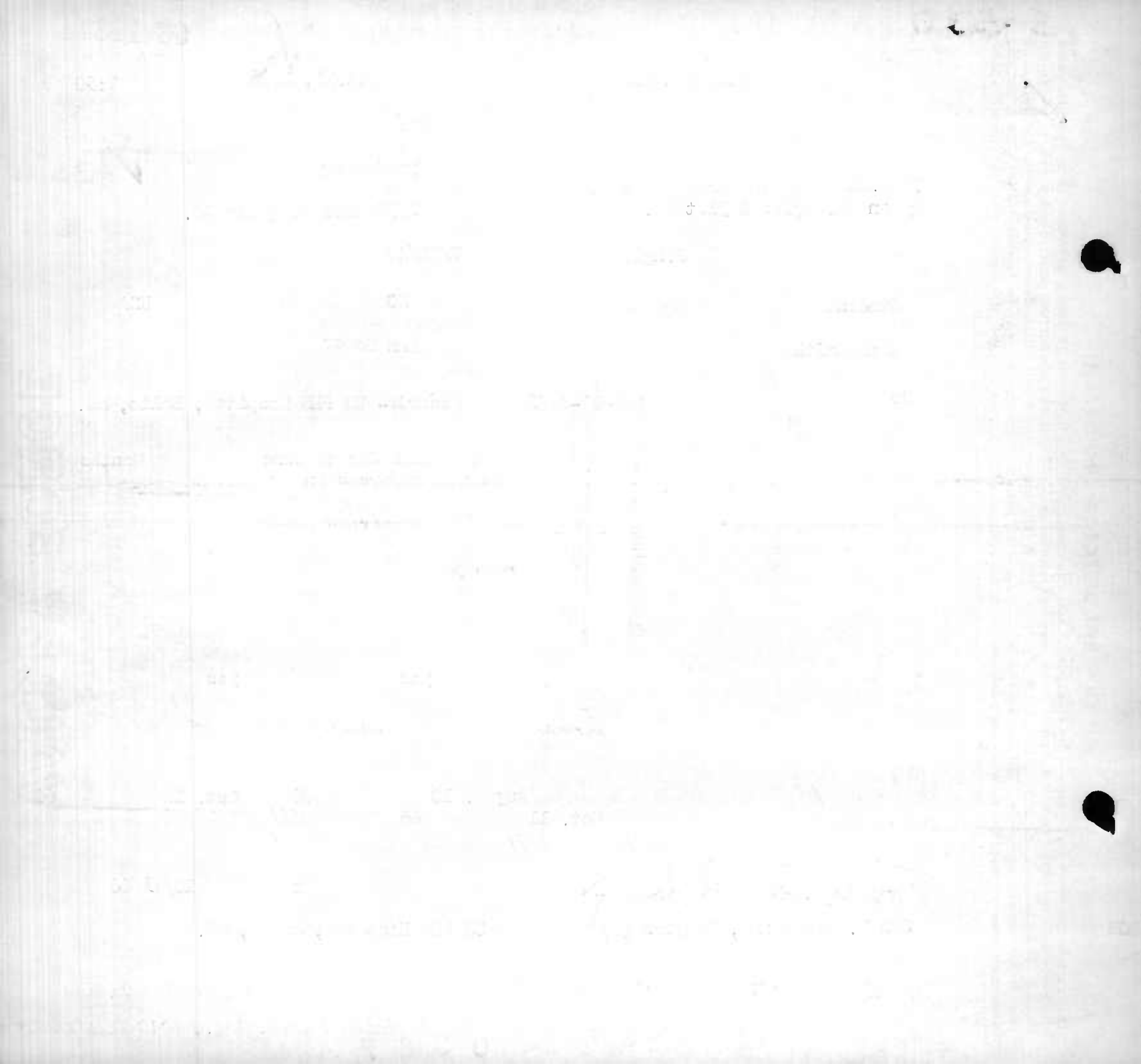
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10374	
<div>66 10374</div> <div>CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print) George Philip Smith			2. DATE AND HOUR OF DEATH Oct. 11, 1966 7:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Pa/ B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 28 US Public Health Service Hospital Wyman Pk. Drive & 31st St.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Wyomissing V-35		
			D. STREET ADDRESS (If rural, give location) 1532 Rose Virginia Rd.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7/31/48	9. AGE (In years last birthday) 18	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clem Smith			14. MOTHER'S MAIDEN NAME Ann Bower		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 88-38-4841		
			17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease injury or complication which caused death.) F-953X Pancytopenia due to bone marrow suppression			INTERVAL BETWEEN ONSET AND DEATH Months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH due to chloramphenicol therapy		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Wyomissing, Pennsylvania V-35		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) Mar 13th July 1966		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Reaction to chloramphenicol and in therapy.		
22. I certify that (I) (this hospital) attended the deceased from Aug 10 19 66 to Oct. 11 19 66, that (I) (we) last saw the deceased alive on Oct. 11 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jon M. Beauchamp			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/13/66
23C. PHYSICIAN'S NAME (Type) Jon M. Beauchamp, Surgeon (R)			23D. ADDRESS M.D. US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/16/66	24C. NAME of CEMETERY or CREMATORY Ash Memorial Garden		24D. LOCATION (City, town, or county) (State) Jefferson, North Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR S. E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown		

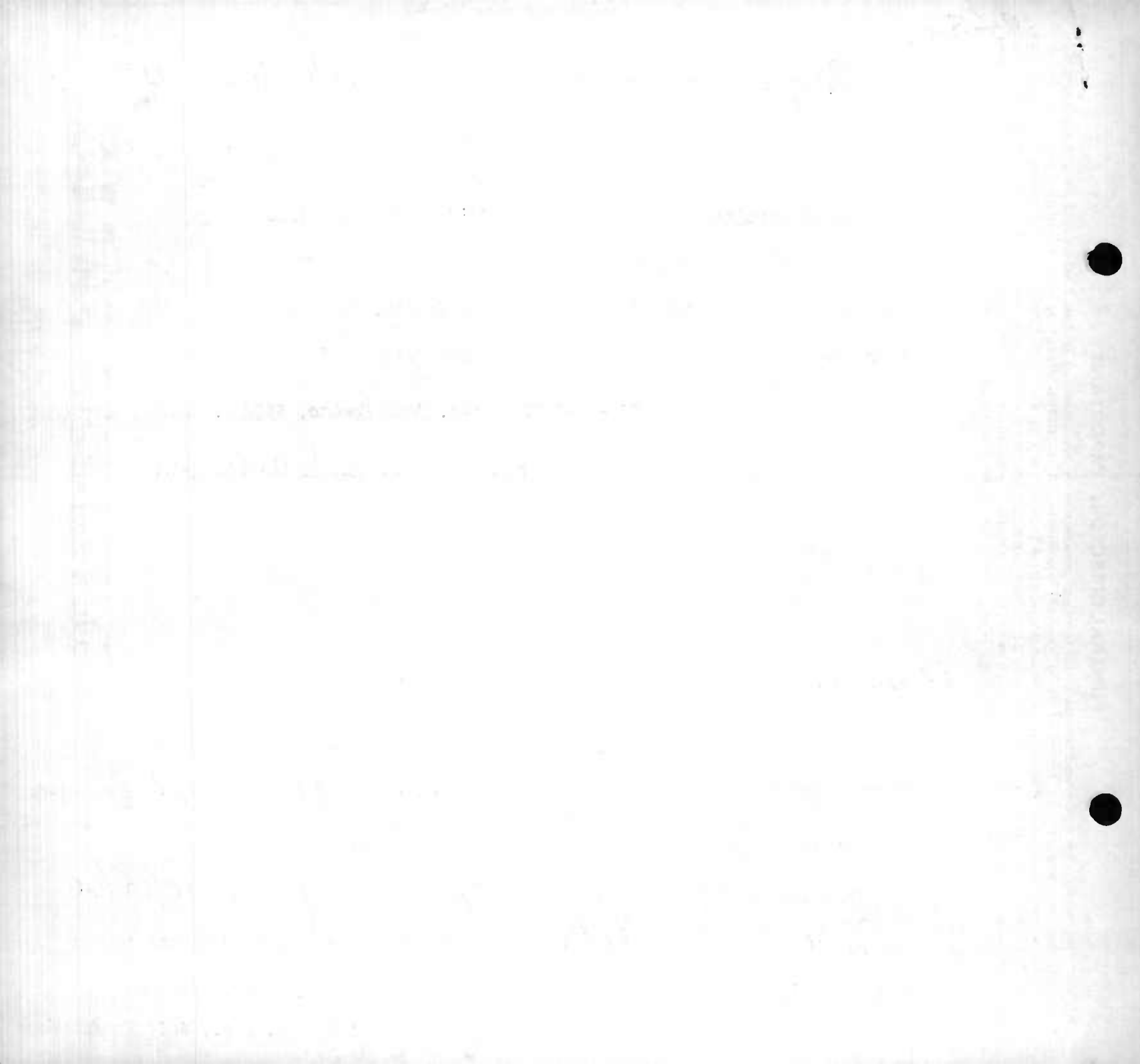


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10375	
BIRTH NO. 66 10375		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Benjamin Rombro		2. DATE AND HOUR OF DEATH 10/12/66 450 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FILL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		A. STATE Maryland B. COUNTY Baltimore			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Max Rombro		14. MOTHER'S MAIDEN NAME Toba Rose ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-26-9837		17. INFORMANT Mrs. Anna Rombro, 3824 W. Cold Spring Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 45-1X I		CAUSE OF DEATH (A) Ruptured aorta aneurysm (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3 wks ago		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/12 19 66 to 10/12 19 66, that (I) (we) lost saw the deceased alive on 10/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MARYIN ROMBRO M.D.				23B. DATE SIGNED 10/12/66	
23C. PHYSICIAN'S NAME (Print) Maryin Rombro, M.D.		23D. ADDRESS Balto, Md. 2409 Rogers Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/14/66		24C. NAME OF CEMETERY or CREMATORY Shomre Adath	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 17 1966			
25B. NAME OF REGISTRAR M. E. F. F. F.		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reisterstown			

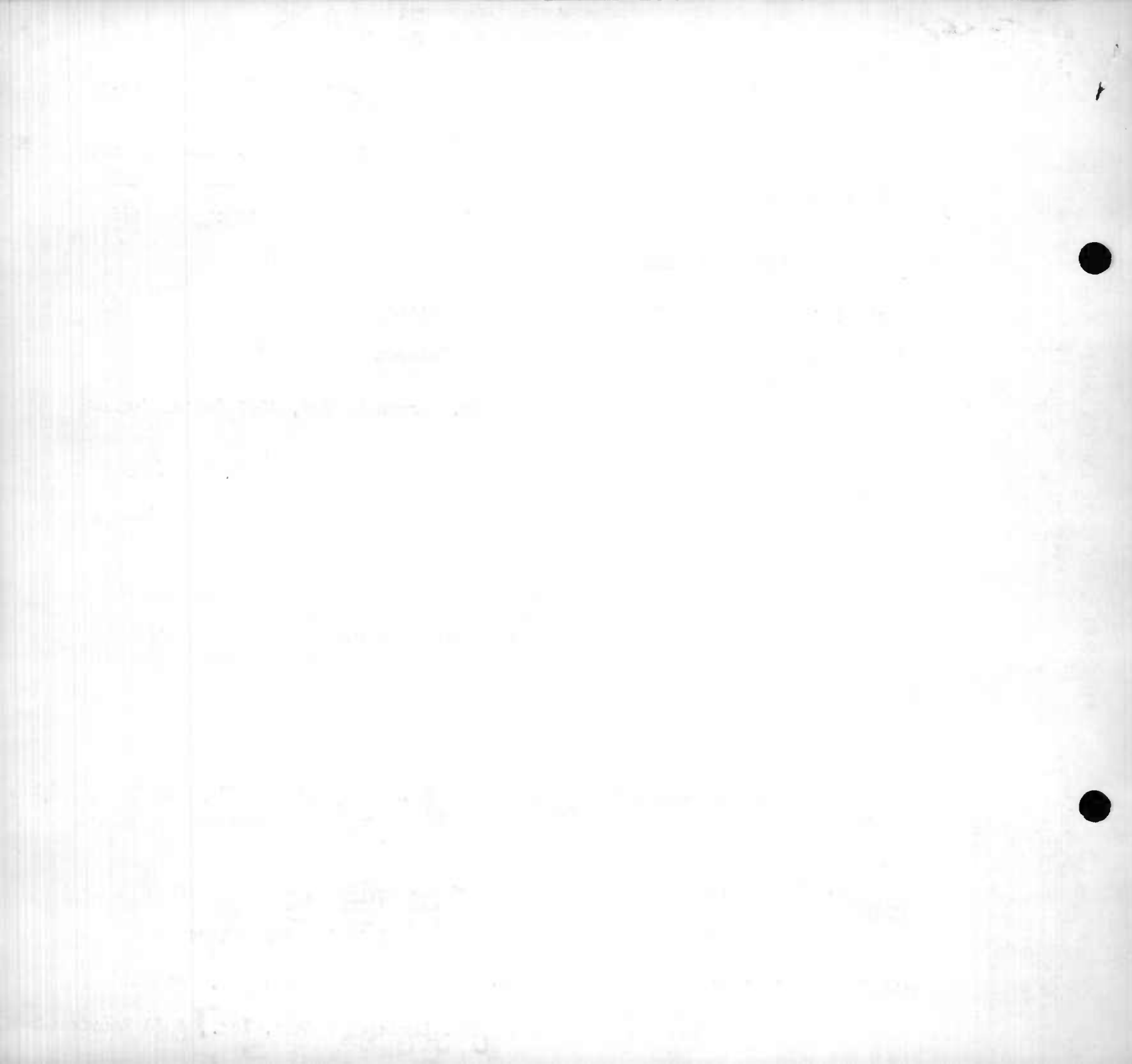




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10376	
BIRTH NO. 66 10376		CERTIFICATE OF DEATH			
M.E. CASE NO. 66 10376					
1. NAME OF DECEASED (Type or Print) <i>Eva Needel</i>		2. DATE AND HOUR OF DEATH <i>October 11, 1966</i>   <i>11:20 A</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>15-13</i> D. STREET ADDRESS (If rural, give location) <i>2549 Park Heights Terrace #15</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>? Adler</i>		14. MOTHER'S MAIDEN NAME <i>Unknown ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT ADDRESS <i>Mr. Herman Needel, 6200 Pearce Avenue</i>	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebrovascular Accident</i>		CAUSE OF DEATH (A) DUE TO <i>HASCD</i> (B) DUE TO <i>Convulsive Disorder?</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Years</i> <i>1 wk.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Mar 1964</i> to <i>Oct 6 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct 6 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Daniel Bakal</i>				23B. DATE SIGNED <i>10.12.66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Daniel Bakal</i>				23D. ADDRESS <i>3600 Lochearn Drive</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/12/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Shomrei Mishmeres</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1966</i>			
25B. NAME OF REGISTRAR <i>Alab E. Falsura</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Sol. Levinson &amp; Bros. Inc., 6010 Reisterstown</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

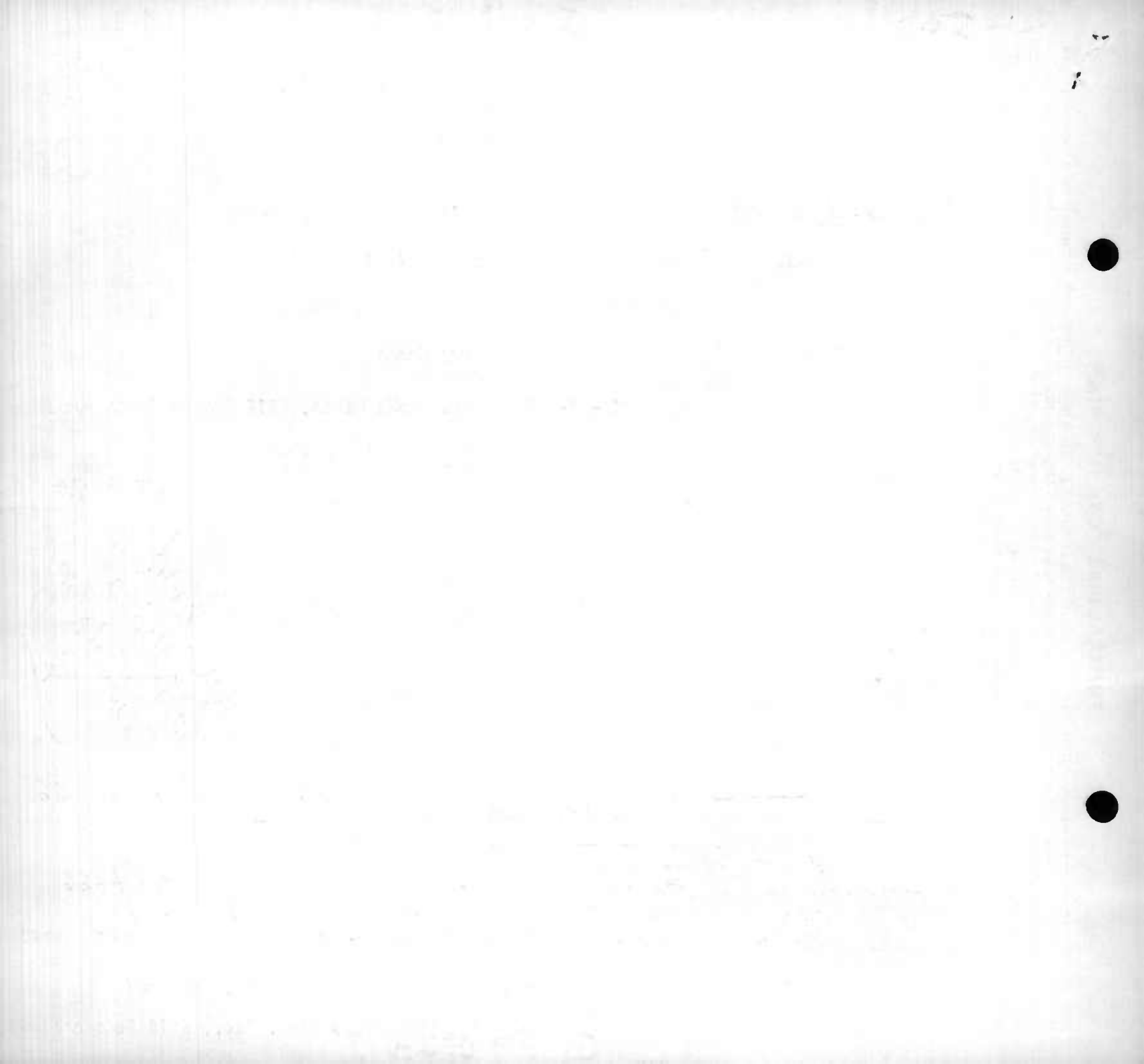
B-4-23		66 10377 BLUESTINE		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10377	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>BLUESTINE, HARRIS</b>		2. DATE AND HOUR OF DEATH <b>10/13/66 10:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balt</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hosp</b>				D. STREET ADDRESS (If rural, give location) <b>3722 Parkfield Rd #8</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>10/13/25</b>	9. AGE (In years, last birth day) <b>41</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>		11. BIRTHPLACE (State or foreign country) <b>Pa. Phila.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Bluestine</b>				14. MOTHER'S MAIDEN NAME <b>Edna?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <b>?</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Leone - Son - Phila. Pa</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>199.2 I</b>				CAUSE OF DEATH (A) DUE TO <b>Adenocarcinoma with Metastasis - site unknown</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION <b>10/14/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/7/66</b> 19 to <b>10/13/66</b> 19, that (I) (we) last saw the deceased alive on <b>10/13/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. H. H.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/13/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Anthony B. Hone</b>				23D. ADDRESS <b>Sinai Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Oct 14/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Montefiore</b>		24D. LOCATION (City, town, or county) (State) <b>Montgomery County, Pa</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Joseph Leone</b>		ADDRESS <b>1001 Pine St - 6010 West Rock</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10378</u>	
BIRTH NO. <u>66 10378</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Isadore Weiner</u>			2. DATE AND HOUR OF DEATH <u>October 14, 1966</u> <u>3 30</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-20</u> D. STREET ADDRESS (If rural, give location) <u>6717 Park Heights Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>August 21, 1903</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Delicatessen Store</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
13. FATHER'S NAME <u>Hymen Weiner</u>			14. MOTHER'S MAIDEN NAME <u>Rae Sachs</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-0036</u>		17. INFORMANT <u>Mrs. Sadie Weiner, 6717 Park Heights Avenue</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MASSIVE CORONARY THROMBOSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Atherosclerotic C.V. Disease</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>this hospital</del> attended the deceased from <u>1956</u> to <u>Oct. 14</u> 19 <u>66</u> , that (I) <del>we</del> last saw the deceased alive on <u>Sept. 20</u> 19 <u>66</u> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>John F. Schaefer M.D.</u> <u>FOR - Dr. Melvin Borden</u>				23B. DATE SIGNED <u>10-14-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER</u> <u>MELVIN BORDEN</u>				23D. ADDRESS <u>401 RANDOM RD. - 21229</u> <u>N. CHAPEL GATE AND RT. #40 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/16/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Bobroisker Verein</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1966</u>		25B. NAME OF REGISTRAR <u>John E. Feltner</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>	





# FUNERAL DIRECTOR: IMPORTANT

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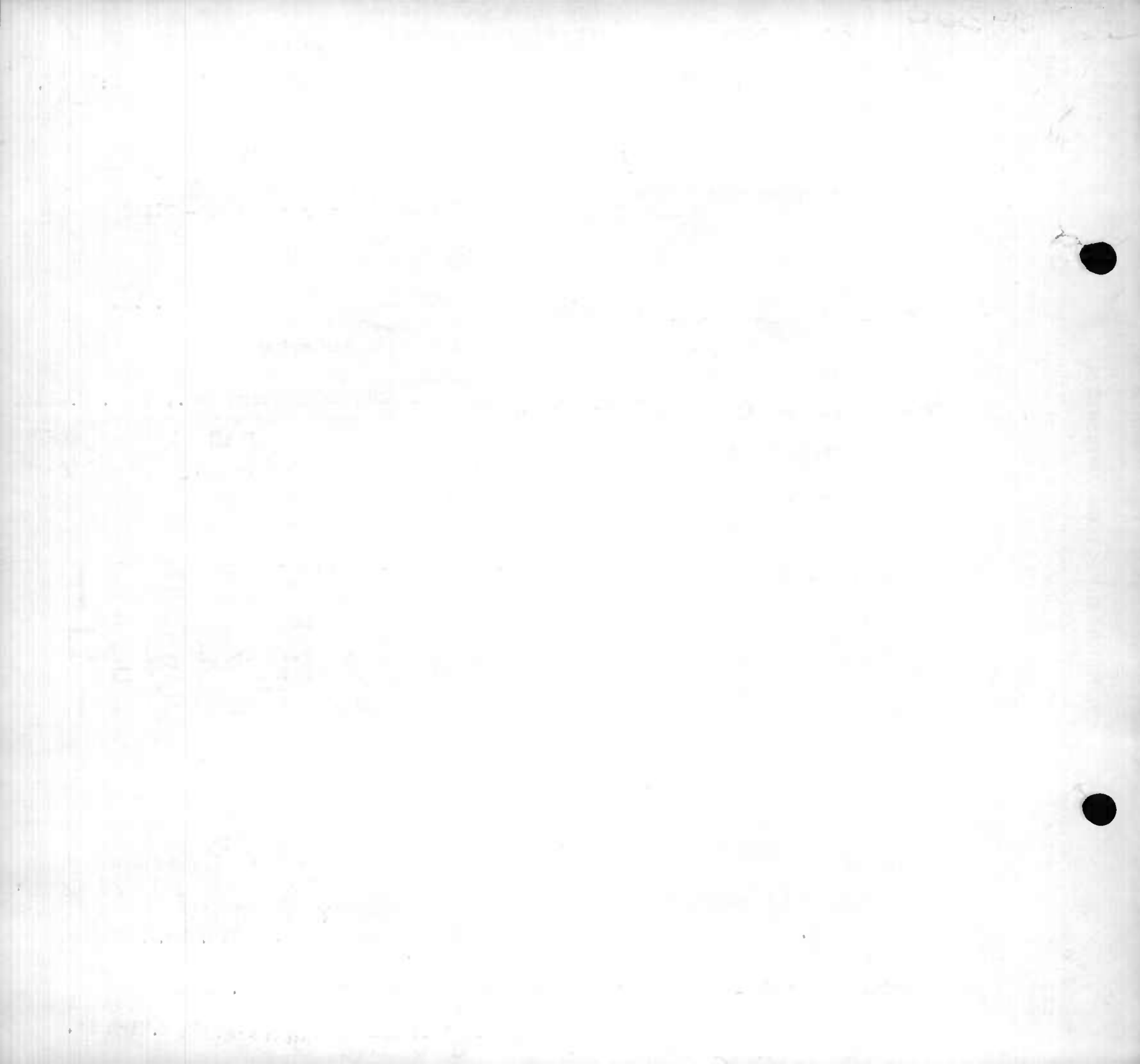
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10379	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 66 10379</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Mamie Stein</i>			<b>2. DATE AND HOUR OF DEATH</b> <i>10/13/66 11<sup>50</sup> a. M.</i>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Belvedere Nursing Home</i>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution's residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____ <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <i>Baltimore 27-17</i> <b>D. STREET ADDRESS</b> (If rural, give location) <i>Belvedere Nursing Home</i>		
<b>5. SEX</b> <i>Female</i>	<b>6. RACE</b> <i>White</i>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <i>Single</i>	<b>8. DATE OF BIRTH</b> <i>Feb. 18, 1884</i>	<b>9. AGE</b> (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>None</i>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>None</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Baltimore, Maryland</i>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>			<b>13. FATHER'S NAME</b> <i>Michael Stein</i>		
<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary ?</i>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
<b>16. SOCIAL SECURITY NO.</b> <i>Unknown</i>			<b>17. INFORMANT</b> ADDRESS <i>Mr. Dan Joseph, 1206 Fidelity Building</i>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>Intestinal obstruction</i> (A) DUE TO <i>cause undetermined &amp; vomiting &amp; hypotension</i> (B) DUE TO _____ (C) DUE TO _____ <b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>5 days</i>					
<b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic heart disease, decompensated</i>					
<b>19A. DATE OF OPERATION</b> <i>0</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		(If in Baltimore City, give exact location)			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>1950</i> <b>to</b> <i>Oct 13, 1966</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Oct. 17, 1966</i> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Jonas Cohen</i>			<b>23B. DATE SIGNED</b> <i>Oct. 13, 1966</i>		M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>JONAS COHEN</i>			<b>23D. ADDRESS</b> <i>6707 Park Heights Ave. Balto. Md. #21215</i>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24B. DATE</b> <i>10/16/66</i>		<b>24C. NAME of CEMETERY or CREMATORY</b> <i>Baltimore Hebrew</i>	
<b>24D. LOCATION</b> (City, town, or county) (State) <i>Baltimore, Maryland</i>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>OCT 17 1966</i> <b>25B. NAME OF REGISTRAR</b> <i>R. G. E. Fisher</i> <b>25C. FUNERAL DIRECTOR</b> <i>Joseph H. Brown &amp; Sons</i> <b>ADDRESS</b>			



## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10380				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10380			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) JOHN BUTTA				2. DATE AND HOUR OF DEATH 10/13/66 2:15 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224				A. STATE MARYLAND B. COUNTY							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE							
				D. STREET ADDRESS (If rural, give location) 513 So Albermarle Street - 21202							
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH 10/27/18		9. AGE (In years last birthday) 48		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self.				10B. KIND OF BUSINESS OR INDUSTRY Service Station				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VINCENT BUTTA				14. MOTHER'S MAIDEN NAME CATHERINE Barberino							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes. II W. W.				16. SOCIAL SECURITY NO. 718-03-0943		17. INFORMANT RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 190.91 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Malignant Melanoma (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (1) (this hospital) attended the deceased from 10-13-66 to 10-13-66, that (1) (we) last saw the deceased alive on 10-13-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. RICHMON				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-13-66			
23C. PHYSICIAN'S NAME (Type) J. RICHMON				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto. Md. 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17-66		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery Baltimore Md. 21229				24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1966		25B. NAME OF REGISTRAR Robert E. Fasham		25C. FUNERAL DIRECTOR Frank Dillamore		ADDRESS 322 S. High St.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>66 10381</u>	
BIRTH NO. <u>66 10381</u>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Earl Halls Adams</u>						2. DATE AND HOUR OF DEATH <u>10-13-66</u> <u>1</u> <u>8</u> a. m.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>						C. CITY OR TOWN (If outside city limits, write BURAN and give township) <u>Baltimore</u> <u>15-37</u>					
D. STREET ADDRESS (If rural, give location) <u>3334 Piedmont Ave</u>											
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>m</u>		8. DATE OF BIRTH <u>1/3/05</u>		9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>B+O. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>						14. MOTHER'S MAIDEN NAME <u>Daisy ?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>705-07-7263</u>		17. INFORMANT <u>Eunice Adams</u>				ADDRESS <u>same</u>	
18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CA lung &amp; metastases</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>radiation fibrosis</u>						CAUSE OF DEATH (A) <u>CA lung &amp; metastases</u> (B) <u>5 mo</u> (C) <u>5 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>radiation fibrosis</u>				20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>Oct 13</u> <u>19</u> <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>A. Skripke</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>10-13-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. Skripke</u>						23D. ADDRESS <u>University Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-17-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1966</u>				25B. NAME OF REGISTRAR <u>Charles R. Law</u>				25C. FUNERAL DIRECTOR ADDRESS <u>802 Madison Ave.</u>			

RECEIVED - 1903

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10382	
BIRTH NO. 66 10382		<b>CERTIFICATE OF DEATH</b>		10-11-66 6:09 AM	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROBERT E.L. WILLIAMS		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
37 MERCY HOSPITAL INC.		Md. BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE #15			
		D. STREET ADDRESS (If rural, give location)			
		4400 Elderson Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 7-23-87	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ENGINEER		Baltimore City		NORTH CAROLINA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
WILLIAM F. WILLIAMS		GEORGIANNA SLEDGE		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214.40.6427		17. INFORMANT ADDRESS	
				SELF	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) ACUTE MYOCARDIAL INFARCT		2 days	
ANTECEDENT CAUSES		(B) CORONARY OCCLUSION		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ACUTE GASTROINTESTINAL HEMORRHAGE		6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Post gastrectomy 8 years			
19A. DATE OF OPERATION 2 1958		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ULCER		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10-8-66 to 10-11-66		that (1) (we) last saw the deceased alive on 10-11-66		and that in (my) (our) opinion death occurred on the date	
23A. SIGNATURE		23B. DATE SIGNED			
STEPHAN J. WITTMANN M.D.		10-11-66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
STEPHAN J. WITTMANN M.D.		MERCY HOSPITAL BALTIMORE, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		10-14-66		DRUID RIDGE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 17 1966		A. D. B. E. Johnson		4600 Liberty Hghts.	

1040 10-11-12

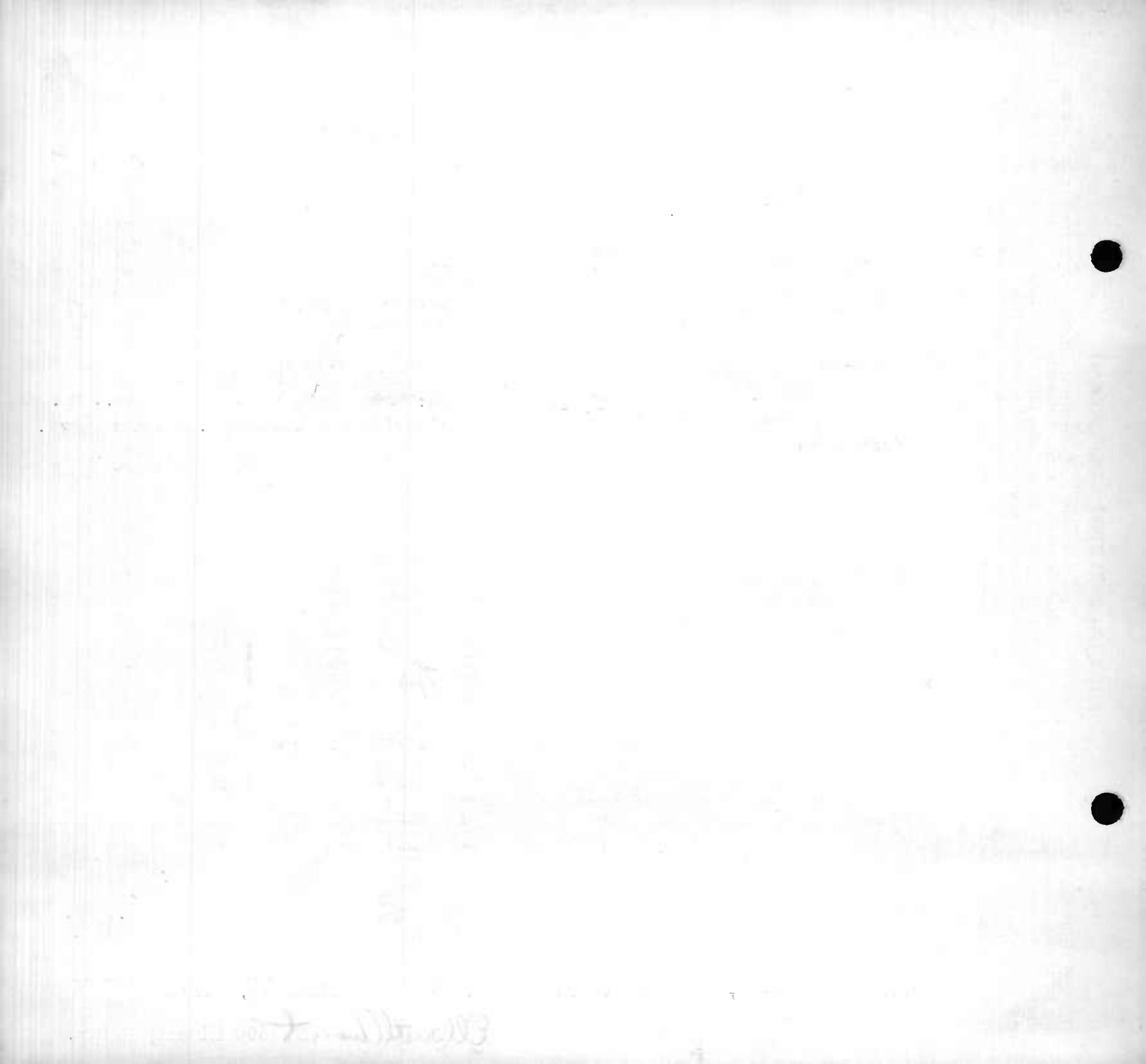
1040 10-11-12



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-92-74 DH				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10383	
BIRTH NO. 66 10383		<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DEWALD, LAURA		2. DATE AND HOUR OF DEATH 10/16/66 125 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALT. CITY HOSPITAL 4940 Eastern Avenue Baltimore, Maryland #21224		(If not in hospital or institution, give street address or location)		A. STATE (PA) Pennsylvania		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) READING V-35			
				D. STREET ADDRESS (If rural, give location) 120 WOODLAND AVE			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1/22/03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Beahm				14. MOTHER'S MAIDEN NAME Rothmel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. 199-01-9838		17. INFORMANT, Baltimore City Hospitals ADDRESS RECORDS: 4940 Eastern Avenue Balto., Md. #24			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Charles DeWald 540 S. Moreland Avenue. ONSET AND DEATH.			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) DUE TO Acute Myocardial infarction 1 hr 20 min			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 10/16 1966 to 10/16 1966, that (1) (we) last saw the deceased alive on 10/16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Allen Ginsberg				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/16/66	
23C. PHYSICIAN'S NAME (Type) ALLEN GINSBERG				23D. ADDRESS 4940 EASTERN AVENUE Balto., Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-19-66		24C. NAME of CEMETERY or CREMATORY Forest Hills Cemetery		24D. LOCATION (City, town, or county) (State) Reading Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1966		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Ellsworth Gower		ADDRESS 4600 Liberty Hghts.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-140		66 10384		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10384	
BIRTH NO.		M.E. CASE NO.		<b>CERTIFICATE OF DEATH</b>		Registered No.	
1. NAME OF DECEASED (Type or Print) <u>Homer Hubble</u>				2. DATE AND HOUR OF DEATH <u>10-15-1966</u> <u>9:45</u> <u>A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> (If not in hospital or institution, give street address or location) <u>10-20-66</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>			
5. SEX <u>Male</u>				6. RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widower</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Duties</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Stone Quarry</u>		8. DATE OF BIRTH <u>9/12/1900</u>	
13. FATHER'S NAME <u>Thomas R. Hubble</u>				14. MOTHER'S MAIDEN NAME <u>MARY HEAD</u>		9. AGE (in years last birthday) <u>66</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-01-1265</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
17. INFORMANT <u>Mr. Howard Hubble, Baltimore 27, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. <u>154X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Villous Adenoma of the Sigmoid and Cecum</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. <u>154X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Villous Adenoma of the Sigmoid and Cecum</u>				(A) DUE TO <u>Villous Adenoma of the Sigmoid and Cecum</u>			
18. <u>154X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Villous Adenoma of the Sigmoid and Cecum</u>				(B) DUE TO <u>SEPTICEMIA</u>			
18. <u>154X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Villous Adenoma of the Sigmoid and Cecum</u>				(C) DUE TO <u>EMPHYSEMA</u>			
18. <u>154X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Villous Adenoma of the Sigmoid and Cecum</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> 19 <u>66</u> to <u>10/15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>SAMI BRAHIM</u>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>SAMI BRAHIM</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-18-1966</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, 1217 St. Paul St.</u>		ADDRESS <u>Baltimore, Md. 21202</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10385</b>	
CERTIFICATE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>M.E. CASE NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <b>Puckett, Houston Reed</b> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <b>Oct. 15 8<sup>50</sup> AM 1966</b> </div> </div>					
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex;"> <div style="flex: 1;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <b>The Union Memorial Hospital</b> </div> <div style="flex: 1;">                     (If not in hospital or institution, give street address or location)                 </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> <b>A. STATE</b>  <b>Md</b> </div> <div style="flex: 1;"> <b>B. COUNTY</b> </div> </div>		
<b>5. SEX</b> <b>M</b>			<b>6. RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <b>Married</b>
<b>8. DATE OF BIRTH</b> <b>04-25-03</b>		<b>9. AGE (In years last birthday)</b> <b>63</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Teacher</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Columbus, MISSISSIPPI</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>American</b>		<b>13. FATHER'S NAME</b> <b>Willis Puckett</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>LITT Unknown Boyd</b>		<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-32-0435</b>	
<b>17. INFORMANT</b> <b>Mrs. Elizabeth B. Puckett</b>			<b>ADDRESS</b> <b>Same</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>203X1 Hemorrhagic Pneumonia</b> <b>Multiple Myeloma</b>					
<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 weeks</b>					
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ATHipolito, M.D</b>					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <b>2</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>yes</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept. 27</b> <b>19 66</b> <b>to</b> <b>Oct. 15 8<sup>50</sup> AM</b> <b>19 66</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Oct 15 8<sup>50</sup> AM</b> <b>19 66</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I) (We)</b> (did) (did not) view the body after death.					
<b>23A. SIGNATURE</b> <b>Sang Won Song</b>				<b>23B. DATE SIGNED</b> <b>OCT. 15. 1966</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>DR SANG WON SONG</b>				<b>23D. ADDRESS</b> <b>M.D. THE UNION MEMORIAL HOSPITAL</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>24B. DATE</b> <b>OCT 18, 1966</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>DRUID RIDGE CEMETERY</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>PIKESVILLE, MARYLAND</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 17 1966</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Wm. Cook-Brooks Tolson</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Wm. Cook-Brooks Tolson</b>			
<b>ADDRESS</b> <b>1050 YORK ROAD TOLSON, MARYLAND 21204</b>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10386				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10386	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WARWICK MARY S.</b>				2. DATE AND HOUR OF DEATH <b>OCT 16, 1966 9 30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hosp.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>Balto Co.</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b>			
				D. STREET ADDRESS (If rural, give location) <b>2822 GARNET RD.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>02-21-04</b>		9. AGE (in years last birthday) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Harland SPURGEON</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH NELSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>342-1P-1340</b>		17. INFORMANT ADDRESS <b>Mr. Nedham C. Warwick 2822 Garnet Rd. 21234</b>			
18. <b>241X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <b>Transient cerebral ischemia</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) <b>Bronchial aspiration w/ broncho pneumonia + atelectasis</b>			
				(C) <b>Status Asthmaticus</b>			
				<b>At Sigmund, M.D.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>10-12-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>respiratory arrest</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-12-66</b> 19 to <b>10-16-66</b> 19, that (I) (we) last saw the deceased alive on <b>10-15</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Zoltan Zarday</b>				M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/16/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ZOLTAN ZARDAY</b>				23D. ADDRESS <b>Unknown The Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/19/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Bolivar, Missouri</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. 1050 York Rd. 21204</b>			

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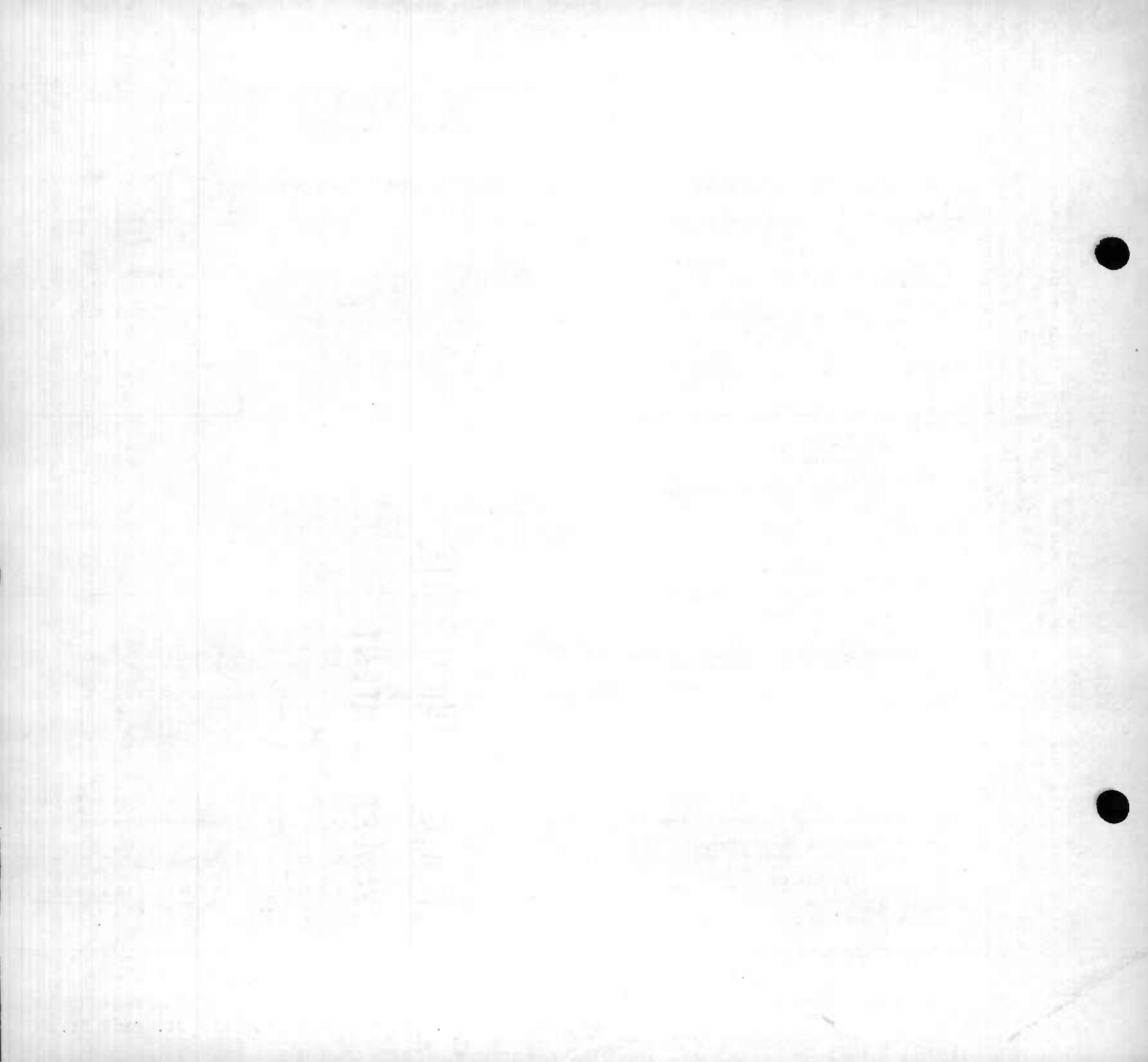


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 10387</span>		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. <span style="font-size: 1.5em;">66 10387</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ALCORN LINDEN MOORE</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10/8/66 8:30 AM.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">FRANKLIN SQUARE HOSPITAL 36</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">19-03</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1520 HOLLINS ST. # 23</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	B. DATE OF BIRTH <span style="font-size: 1.2em;">9/28/06</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">60</span>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MEAT INSPECTOR</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">IOWA</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">HARVEY A. ALCORN</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARGARET MOORE (DECEASED)</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">YES ARMY 3F</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">336-20-183F</span>			17. INFORMANT <span style="font-size: 1.2em;">MRS. HELEN HAYES-1520 Hollins St.</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">5-27-11</span>			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Acute Pulmonary Edema, Bil.</span> DUE TO (B) <span style="font-size: 1.2em;">COR BOVINUM 2°</span> DUE TO (C) <span style="font-size: 1.2em;">OBSTRUCTIVE EMPHYSEMA MARKED BILATERAL</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">II</span>			INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">20 12 DAYS</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9/30</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">10/8</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/8</span> 19 <span style="font-size: 1.2em;">66</span> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Thomas A. Alvero</span>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">10/8/66</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">THOMAS A. ALVERO</span>			23D. ADDRESS <span style="font-size: 1.2em;">FRANKLIN SQUARE HOSPITAL</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">10/15/66</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Prospect Hill Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Towson, Maryland 21204</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">O. G. E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wm. Cook-Brooks Inc. 1217 St. Paul St.</span>	

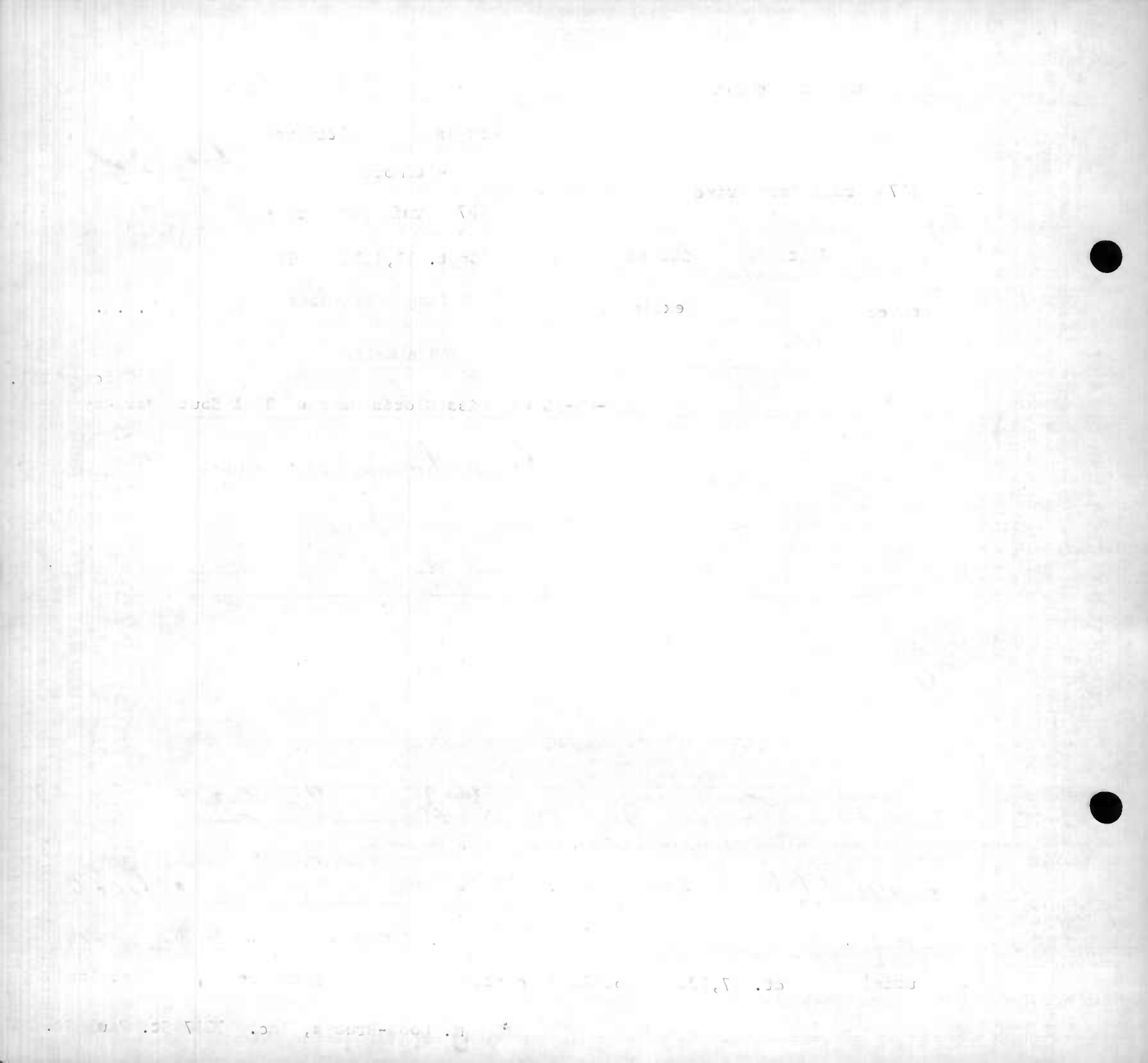
OCT 17 1966



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

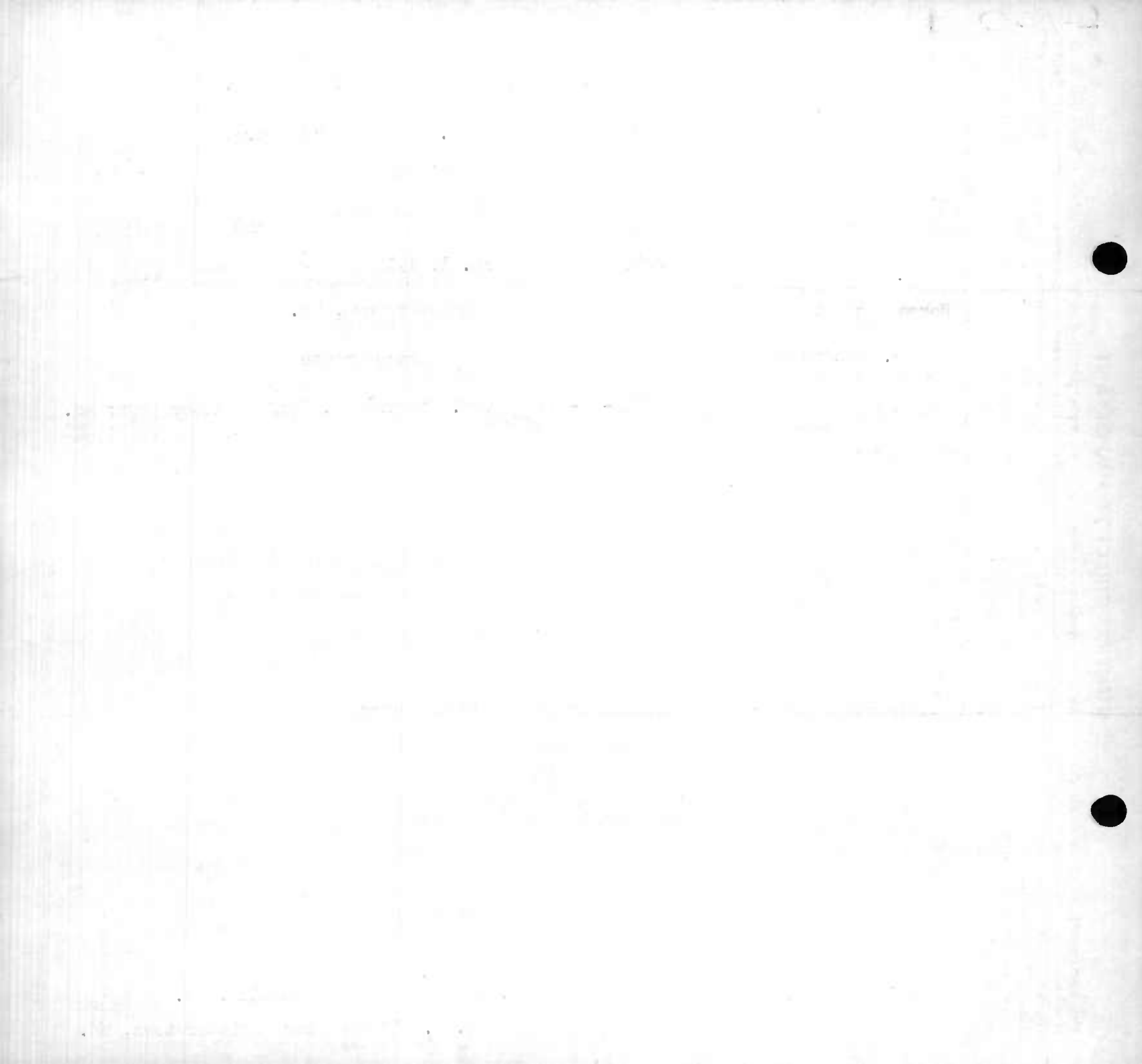
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10388		CERTIFICATE OF DEATH		Registered No. 66 10388	
1. NAME OF DECEASED (Type or Print) <b>Aurelia George</b>				2. DATE AND HOUR OF DEATH <b>Oct. 14, 1966</b> <b>7<sup>30</sup> a. m.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2274 Druid Park Drive</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2274 Druid Park Drive</b>					
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept. 11, 1898</b>		9. AGE (In years last birthday) <b>68</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>SANFER POPE</b>				14. MOTHER'S MAIDEN NAME <b>MARIA GALAN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-03-5800A</b>		17. INFORMANT <b>Miss Gloria George 3001 South Parkway Chicago Ill.</b>				
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Branchopneic Carcinoma</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 wks.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 9</b> 19 <b>43</b> to <b>Oct 14</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Jan 12</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Louis V. Blum, M.D.</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/14/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Louis V. Blum, M.D.</b>				23D. ADDRESS <b>3502 W. Rogers Ave Balto, Md 21215</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 17, 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10389</u>	
BIRTH NO. <u>66 10389</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Kenneth Leaf</u>		2. DATE AND HOUR OF DEATH <u>October 13th 1966 12:50 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Sinai Hospital of Baltimore</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Reisterstown</u> D. STREET ADDRESS (If rural, give location) <u>53-00</u> <u>219 Main Street</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 1, 1913</u>	9. AGE (In years lost birthday) <u>53</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Trainer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Reisterstown, Md.</u>	
13. FATHER'S NAME <u>G. Frank Leaf</u>		14. MOTHER'S MAIDEN NAME <u>Grace Crouse</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-3135</u>		17. INFORMANT <u>Mrs. Margaret H. Leaf</u> ADDRESS <u>Reisterstown, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>260X I</u>		CAUSE OF DEATH (A) <u>Uremia</u> DUE TO (B) <u>Pyelonephritis (chronic)</u> DUE TO (C) <u>Nephrosclerosis arteriosclerotic (Kimmelstiel Wilson)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>		20. <u>Diabetes Mellitus</u>		<u>25 years</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 8th 1966</u> to <u>October 13th 1966</u> , that (I) (we) last saw the deceased alive on <u>October 13th 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William Cieplinski</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>13 Oct. 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>William Cieplinski</u>		23D. ADDRESS <u>Sinai Hospital Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/15/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>J. F. Elmer &amp; Sons</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Reisterstown, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10390	
CERTIFICATE OF DEATH					
BIRTH NO. 66 10390					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Stanley Hornstein		2. DATE AND HOUR OF DEATH October 12, 1966 3:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 4516 Umatilla Avenue Baltimore, Maryland 21215		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4516 Umatilla Ave. 21215			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 8/19/1912	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collector Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Abraham Hornstein		14. MOTHER'S MARDEN NAME Freda Elkon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-03-0293		17. INFORMANT ADDRESS Beatrice H. Hornstein 4516 Umatilla Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardio-Respiratory Failure Due to Carcinoma of Pancreas (B) Generalized Abdominal Metastasis Due to (C)			
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar 17 1963 to Oct 12 1966, that (I) (we) last saw the deceased alive on Oct 12 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE William D. Applefeld		23B. DATE SIGNED 5/13/66		23C. PHYSICIAN'S NAME (Type) William D. Applefeld	
23D. ADDRESS 5507 Park Heights Dr		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/13/66		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew Congregation Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. OCT 17 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Jack Lewis, Inc. 2100 Eutaw Place		25D. ADDRESS			

Charles W. Johnson  
President  
American Red Cross  
New York, N. Y.

Charles W. Johnson  
President  
American Red Cross  
New York, N. Y.



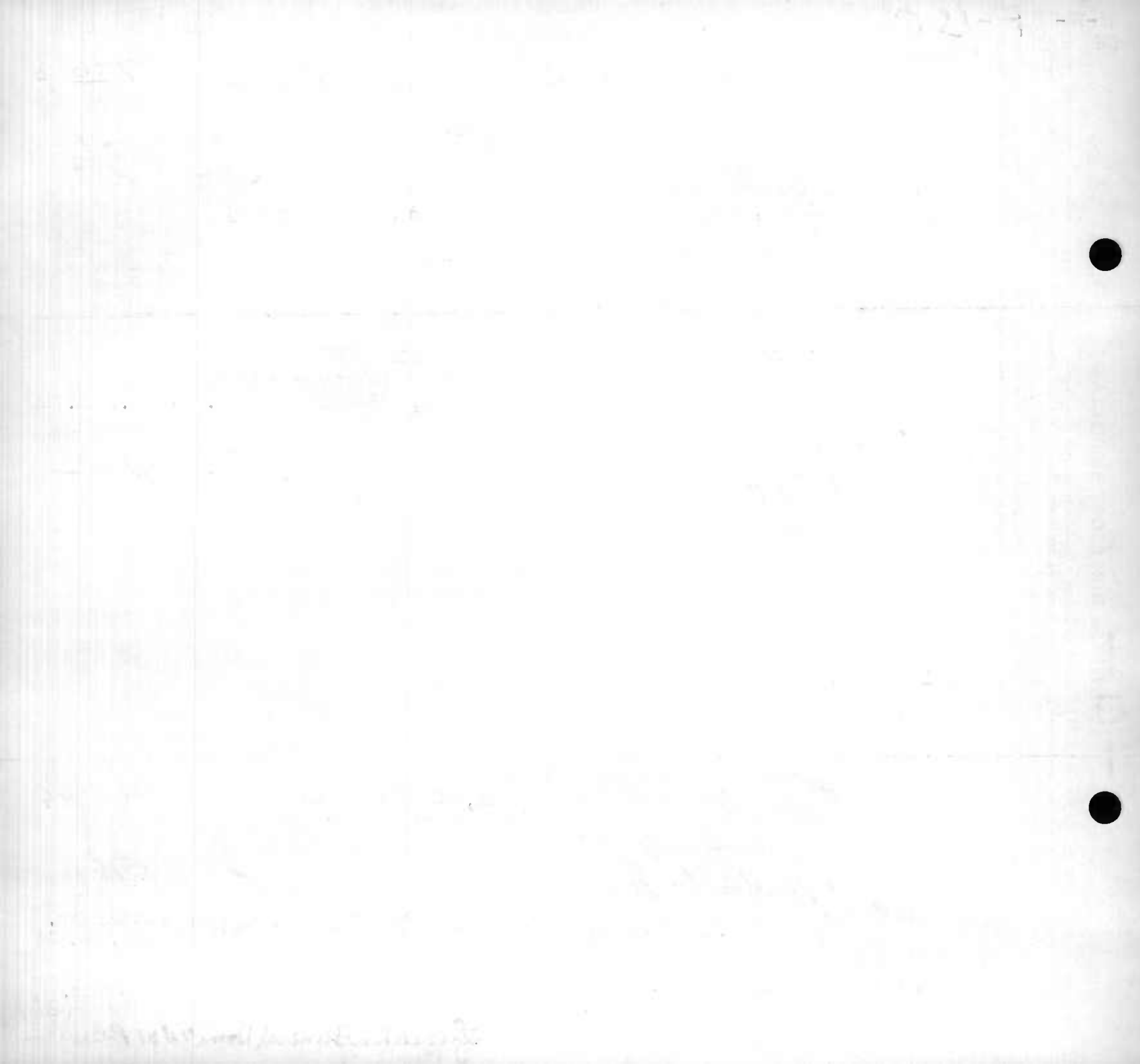
45-98-28

DH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10391	
<div style="display: flex; justify-content: space-between;"> <span>45-98-28</span> <span>66 10391</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>M.E. CASE NO.</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>FABIAN, Marie</b>			2. DATE AND HOUR OF DEATH <b>10/14/66 7:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>26-36</b> D. STREET ADDRESS (If rural, give location) <b>1001 Kewitt Way #21205</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11-8-82</b>	9. AGE (In years last birthday) <b>83</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Romania</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Marie Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Baltimore City Hospitals</b> ADDRESS <b>4940 Eastern Ave. Balto., Md. #24</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>199.2 I</b> <b>CAUSE OF DEATH</b> <b>Carcinoma, primary site unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0 2/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tracheostomy</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>21, Feb 1966</b> to <b>10/14 1966</b> , that (X) (we) last saw the deceased alive on <b>10/14 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Franklin G. Strauss</b> M.D.			23B. DATE SIGNED <b>10/14/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Franklin G. Strauss</b> M.D.			23D. ADDRESS <b>Balt City Hops</b> <b>4940 Eastern Ave. Baltimore, Md. #24</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-18-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Castle View Memorial Cem</b>	
24D. LOCATION (City, town, or county) <b>New Castle,</b>		24E. STATE (State) <b>Penna.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DET 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Lazarus Funeral Home 7401 Belair Road</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10392		CERTIFICATE OF DEATH		Registered No. 66 10392		
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH TIPPNER</b>						2. DATE AND HOUR OF DEATH <b>10-15-66</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>434 N. ROSE ST.</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>6-02</b> D. STREET ADDRESS (If rural, give location) <b>434 N. ROSE ST.</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>1-1-1883</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>HUNGARIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>PETER TILL</b>						14. MOTHER'S MAIDEN NAME <b>KATHERINE BRILL</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mrs. Magdalena Strack - 6929 Sonora Drive Jacksonville, Fla.</b>				ADDRESS	
18. <b>434.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Chronic Heart Failure</b> DUE TO (B) <b>Myocardial Insufficiency</b> DUE TO (C) <b>General Anoxia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 Wks.</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>Jan 10 - 1966</b> to <b>Oct 15 - 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct 15 - 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>didn't</del> ) view the body after death.										
23A. SIGNATURE <b>Wm. G. Geyer</b>						M.D. <input checked="" type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Oct 17 - 66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Wm. G. GEYER</b>						23D. ADDRESS <b>156 N. MILTONA - BALTO. - Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-18-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>PARKWOOD CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Fink</b>			25C. FUNERAL DIRECTOR <b>Anthony J. Hill</b>		ADDRESS <b>2334 Jefferson St.</b>		



G-612

66 10393

BALTIMORE CITY HEALTH DEPARTMENT

66 10393

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES JOHN GREBOS, SR.

2. DATE AND HOUR PRONOUNCED DEAD

October 15, 1966 9:29 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

914 North Castle Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

8-3-1902

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

INSPECTOR

10B. KIND OF BUSINESS OR INDUSTRY

BETHLEHEM STEEL

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

YES

1922-1936

16. SOCIAL  
SECURITY NO.

213-07-4746

17. INFORMANT

ADDRESS

Mr. John M. Grebos - 517 S. Shores St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/15/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-19-66

23C. NAME of CEMETERY or CREMATORY

BALTIMORE CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 17 1966

R. E. Fairbank

Hartley Hill, 2334 Jefferson St.

4 2-3-1902

Unknown

Unknown

12-12-1901 12-12-1901 12-12-1901

12-12-1901

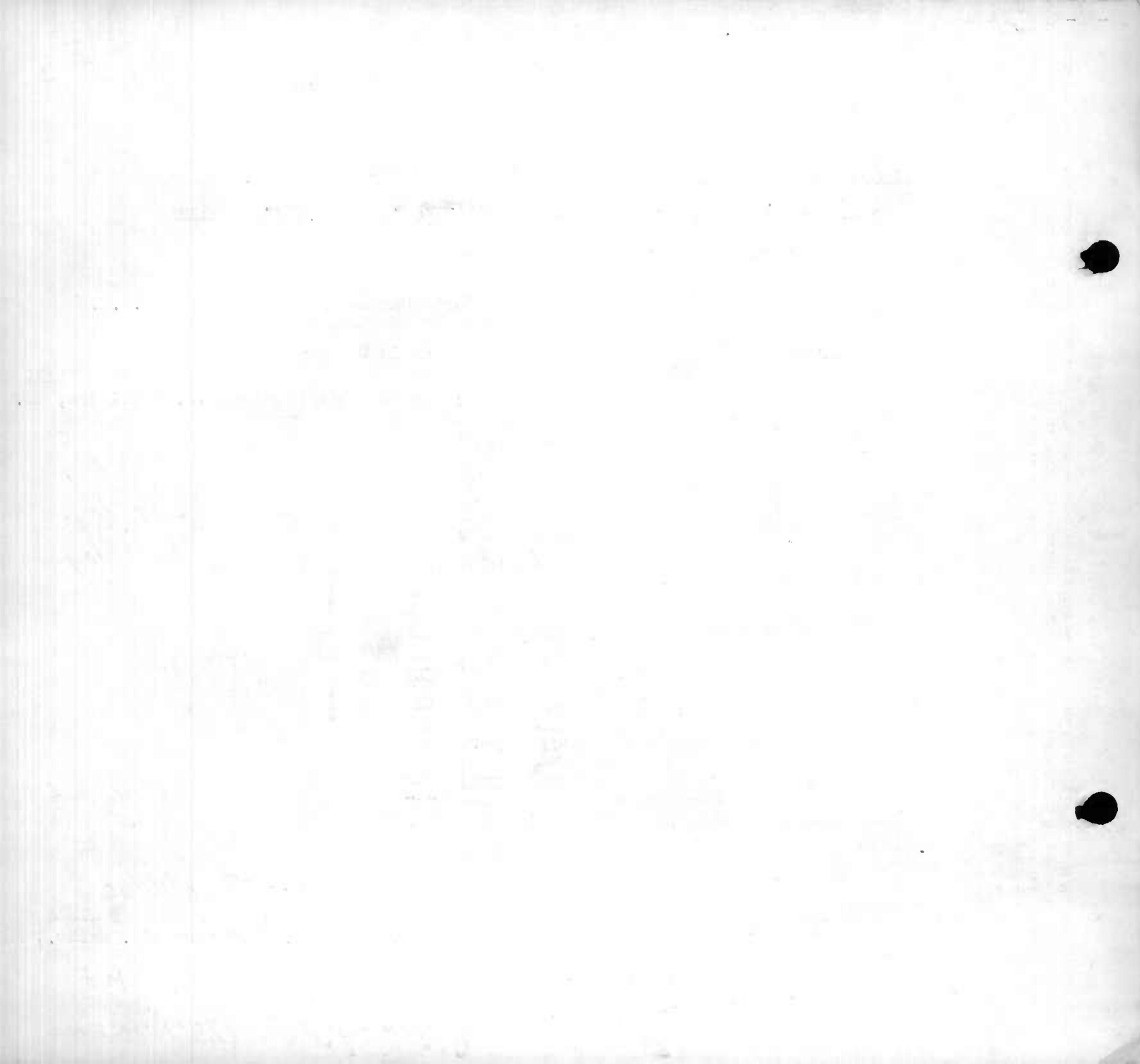
12-12-1901 12-12-1901 12-12-1901

12-12-1901 12-12-1901 12-12-1901

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Robert Crump		10/14/66 11:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave. (BCH) # 21224			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/6/84	9. AGE (In years lost birthday) 82	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Soloman Crump		14. MOTHER'S MAIDEN NAME Annie Carter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS # 21224 BCH: Records 4940 Eastern Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 493X14029X		CAUSE OF DEATH (A) Pneumonia (B) Urinary tract infection (C) Bacteremia		INTERVAL BETWEEN ONSET AND DEATH 2-3 days 2-3 days 2-3 days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple CVAs, ? lues					
19A. DATE OF OPERATION 2/7/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RPH		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-4-1962 to 10/14/66, that (1) (we) last saw the deceased alive on 10/14/66 and that in my opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Straus		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/14/66	
23C. PHYSICIAN'S NAME (Type) F. STRAUS		23D. ADDRESS M.D. Balt City 4940 Eastern Ave. Balto., Md.		# 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-18-66		24C. NAME OF CEMETERY or CREMATORY MT. AUBURN	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR MORTON + DYRTI	
24G. ADDRESS 1701 LAURENS		24H. NAME OF REGISTRAR		24I. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

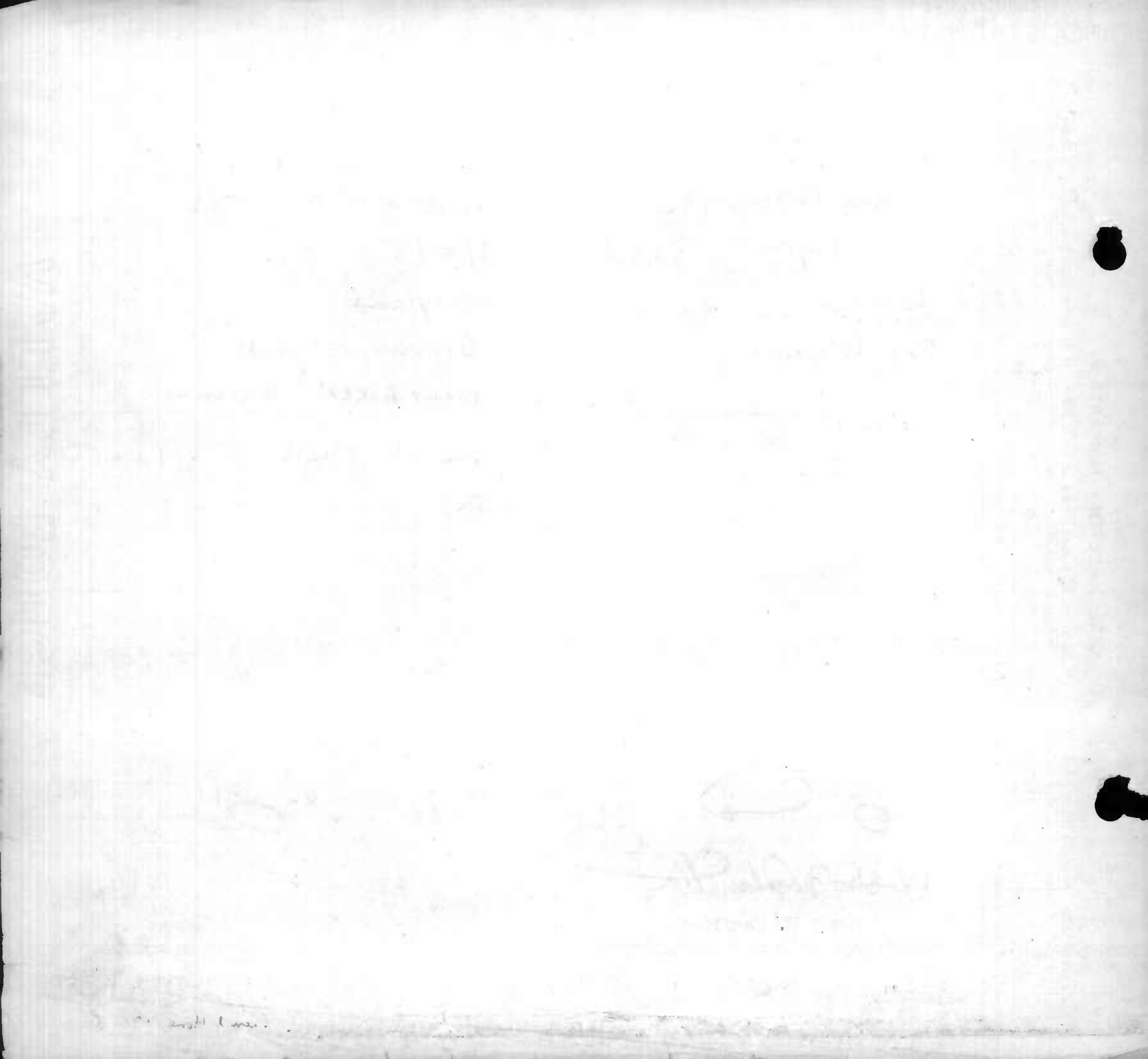




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

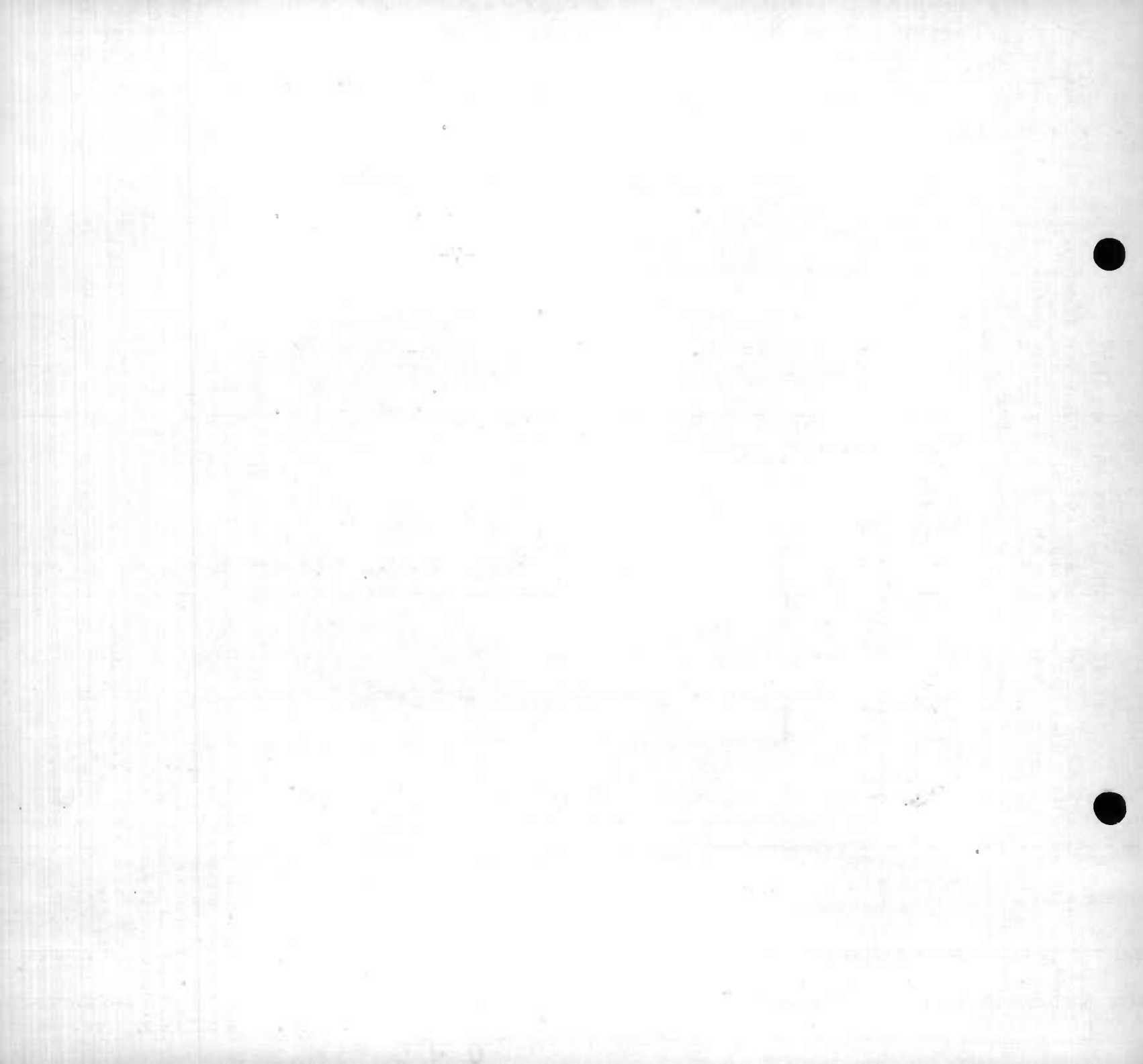
BIRTH NO. 66 10395				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10395	
M.E. CASE NO. 66 10395				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type in Print) PALMER, EDWARD ALEXANDER				2. DATE AND HOUR OF DEATH 10/11/66 11 46 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITR HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-02			
				D. STREET ADDRESS (If rural, give location) 1832 LAURENS STREET			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1/30/15	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Race Track		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray Palmer				14. MOTHER'S MAIDEN NAME Genevieve Cook			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-6498		17. INFORMANT MARY AIKEN		ADDRESS 1832 LAURENS ST	
18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) Neoplasm of Brain (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 month			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (B) DUE TO (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/4 19 66 to 10/11 19 66 that (I) (we) last saw the deceased alive on 10/11 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert M. Hamilton				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/11/66	
23C. PHYSICIAN'S NAME (Type) Robert M. Hamilton				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-15-66		24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR The McGraw-Hill Funeral Home, 1701 Laurens St		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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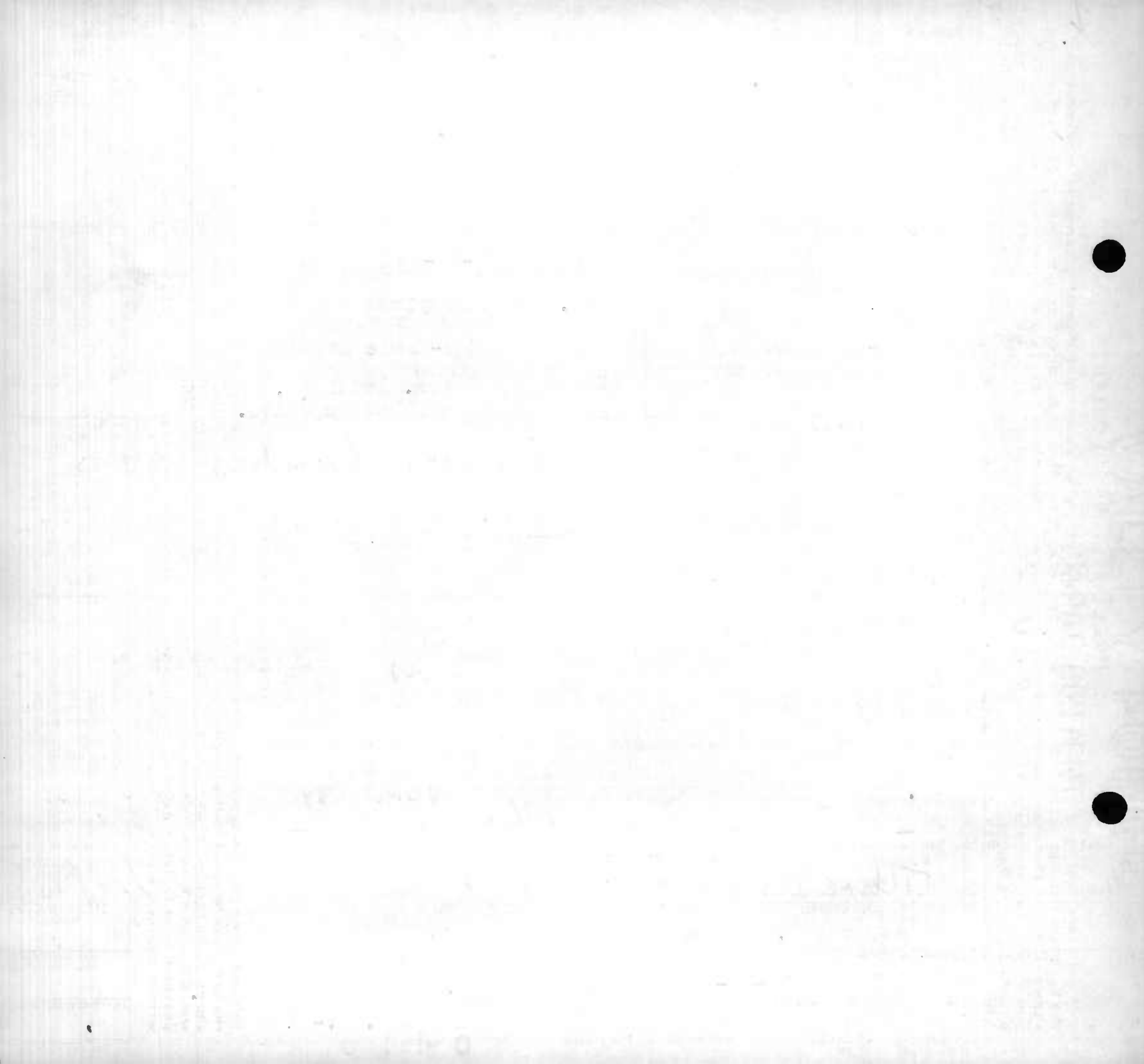
BIRTH NO. <b>66 10396</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 10396</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Emma Leroy</b>			2. DATE AND HOUR OF DEATH <b>Oct. 13, 1966</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 German Aged Peoples Home 22 S. Athol Ave. 21229</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>28-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>22 S. Athol Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>6-7-81</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trimmer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Embroidery Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Late- Frederick M. Zerowski</b>			14. MOTHER'S MAIDEN NAME <b>Late-Renate Zielke</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Gen. German Aged Home records 22 S. Athol Ave.</b>	
18. <b>450.17-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Toxemia from gangrene</b> DUE TO (B) <b>of fat by secondary to</b> DUE TO (C) <b>advanced arterio sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Diabetes mellitus</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>13 Oct 1966</b> , that (I) (we) last saw the deceased alive on <b>13 Oct 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William J. Bryson</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>14 Oct 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>William J. Bryson</b>		23D. ADDRESS <b>4605 Edmondson Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-15-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke Fun. Dir. 4101 Ed. Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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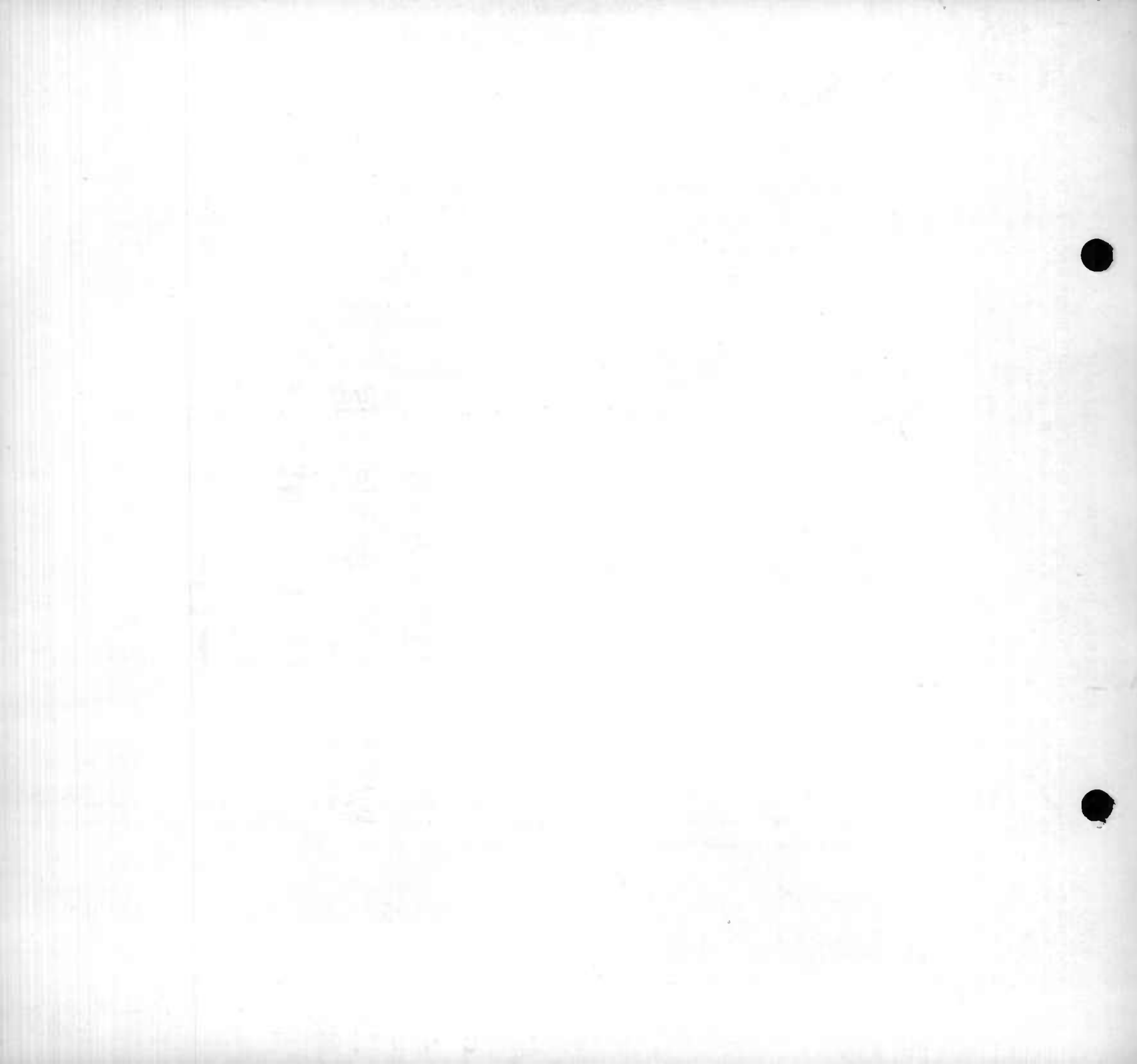
BALTIMORE CITY HEALTH DEPARTMENT		66 10397	
BIRTH NO. 66 10397		Registered No. 66 10397	
M.E. CASE NO.		1. NAME OF DECEASED	
(Type or Print)		James O. Murphy	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.	
4905 Alson Drive		October 14, 1966 10:40 A.M.	
5. SEX M		6. RACE Wh	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 8-18-94	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) 72	
Retired		10. BIRTHPLACE (State or foreign country) Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late-Roger Murphy		14. MOTHER'S MAIDEN NAME Late-Madie Schauck	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mattie V. Murphy 4905 Alson Drive.		ADDRESS	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 2 HRS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CORONARY ARTERIO-SCLEROSIS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		20A. AUTOPSY? (Yes or No) No	
19A. DATE OF OPERATION 0		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21D. TIME OF INJURY (Approx.)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1964 to 10/14 1966, that (I) (we) last saw the deceased alive on 10/14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Thomas E. Roache	
23B. DATE SIGNED 10/14/66		23C. PHYSICIAN'S NAME (Type) Thomas E. Roache	
23D. ADDRESS 5550 Baltimore National Pike		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 10-17-66		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 17 1966	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke F. D.-4101 Edmondson Av.	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10398		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10398	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>FURHRMAN, MAMIE HESTER</b>			10-12-66 10:40 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Union Memorial Hosp. 44</b>			A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 2109</b> D. STREET ADDRESS (If rural, give location) <b>1435 Winston Av.</b>		
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11-29-78</b>	9. AGE (In years last birthday) <b>87</b>	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jacob N. De Hoff</b>			14. MOTHER'S MAIDEN NAME <b>Mary Hoyer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-54-0491</b>		17. INFORMANT <b>WILLIAM N. FUHRMAN</b> ADDRESS <b>2112 1435 WILSON AVE - BALTIMORE MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>170X I</b>			CAUSE OF DEATH (A) DUE TO <b>Cancer of breast</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>10-22-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of breast</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>9-26-66</b> to <b>10-12-66</b> , that (H) (we) last saw the deceased alive on <b>10-12-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Felix J. Martin</b> M.D.			23B. DATE SIGNED <b>10-12-66</b>		23C. PHYSICIAN'S NAME (Type) <b>Felix J. Martin</b> M.D.
23D. ADDRESS <b>The Union Memorial Hospital</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		
24B. DATE <b>10/15/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREENMOUNT CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>GREENMOUNT, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>John E. Goff</b> ADDRESS <b>2107 N. Hampstead md.</b>	

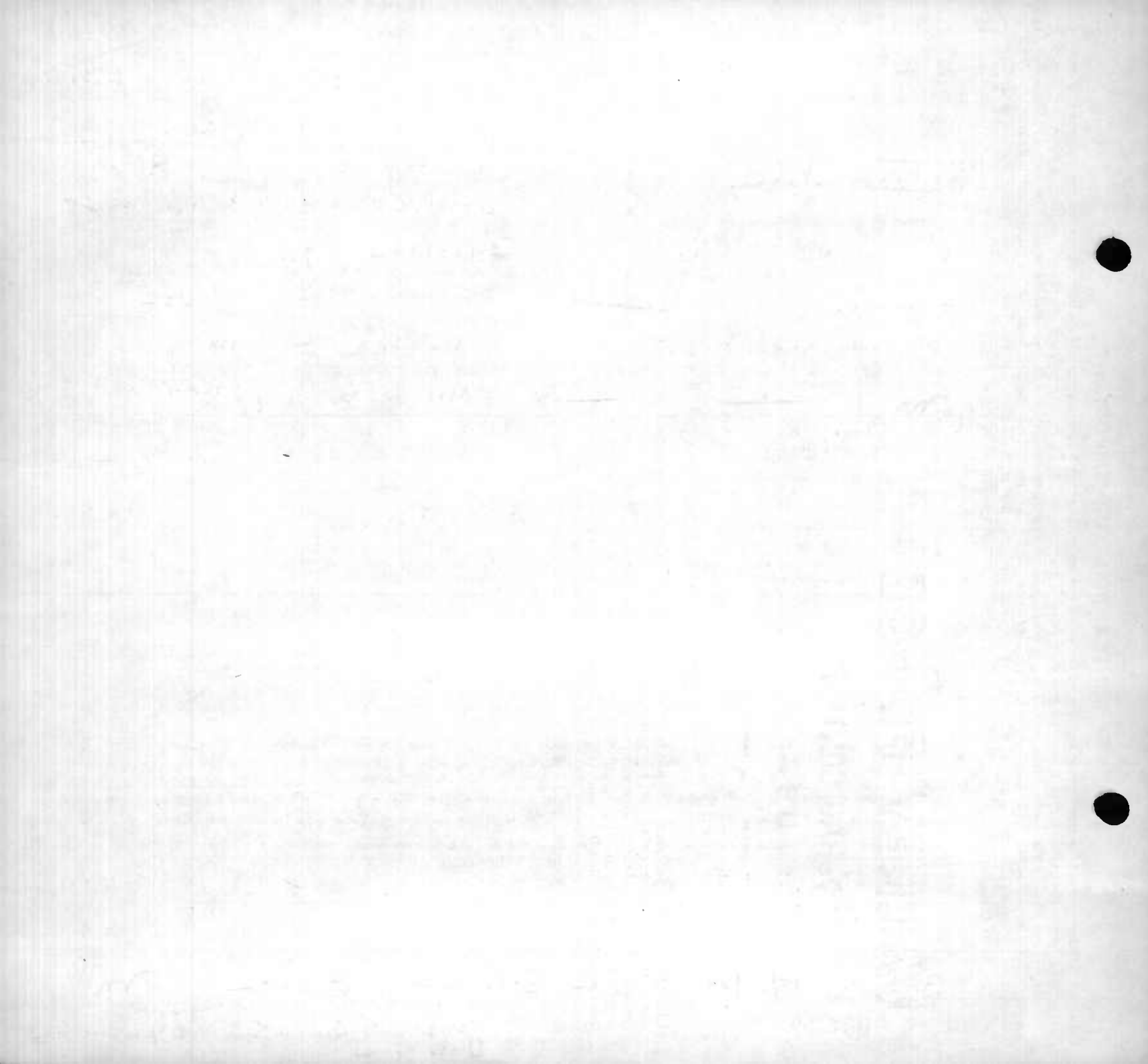




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 10399					CERTIFICATE OF DEATH		Registered No. 66 10399		
1. NAME OF DECEASED (Type or Print) <b>Edna WHITEHILL</b>					2. DATE AND HOUR OF DEATH <b>12:35 10-15-66 12.35 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>91 Levindale</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 27-17</b> D. STREET ADDRESS (If rural, give location) <b>Levindale Hebrew Home &amp; Infirmary</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W.</b>	8. DATE OF BIRTH <b>4-17-1894</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Marcus Kleineibst</b>					14. MOTHER'S MAIDEN NAME <b>Bertha Goldsmith</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Hilda Wolf</b>			ADDRESS <b>4644 Pk. Hgts. Ave Baltimore 21215</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>					CAUSE OF DEATH (A) <b>CVA</b> DUE TO (B) <b>ASCVD</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 Hour</b> <b>10 yrs.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1-4-1955</b> to <b>10-15-1966</b> , that (I) (we) last saw the deceased alive on <b>10-15-66</b> 19 and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) <b>(did)</b> (did not) view the body after death.									
23A. SIGNATURE <b>Joe Ardair</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-15-66</b>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/17/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Oheb Shalom</b>		24D. LOCATION (City, town, or county) (State) <b>Baltow Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son</b>		ADDRESS <b>3319 Olympia Ave</b>			



1  
W-452

66 10400

BALTIMORE CITY HEALTH DEPARTMENT

66 10400

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

October 8, 1966 12:00 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)33  
99 John Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

947 N. Broadway

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

B. DATE OF BIRTH

1-8-1925

9. AGE (in years  
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labour

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Willie Williams

14. MOTHER'S MAIDEN NAME

Gibson Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Burl Hood - 523 Preston St

1B.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of chest  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

tavern

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Sportsmans Bar 1800 Ashland Avenue

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

10-8-66 11:45 P.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Shot by unknown assailant

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-15-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

Balto.

(City, town, or county)

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

OCT 17 1966

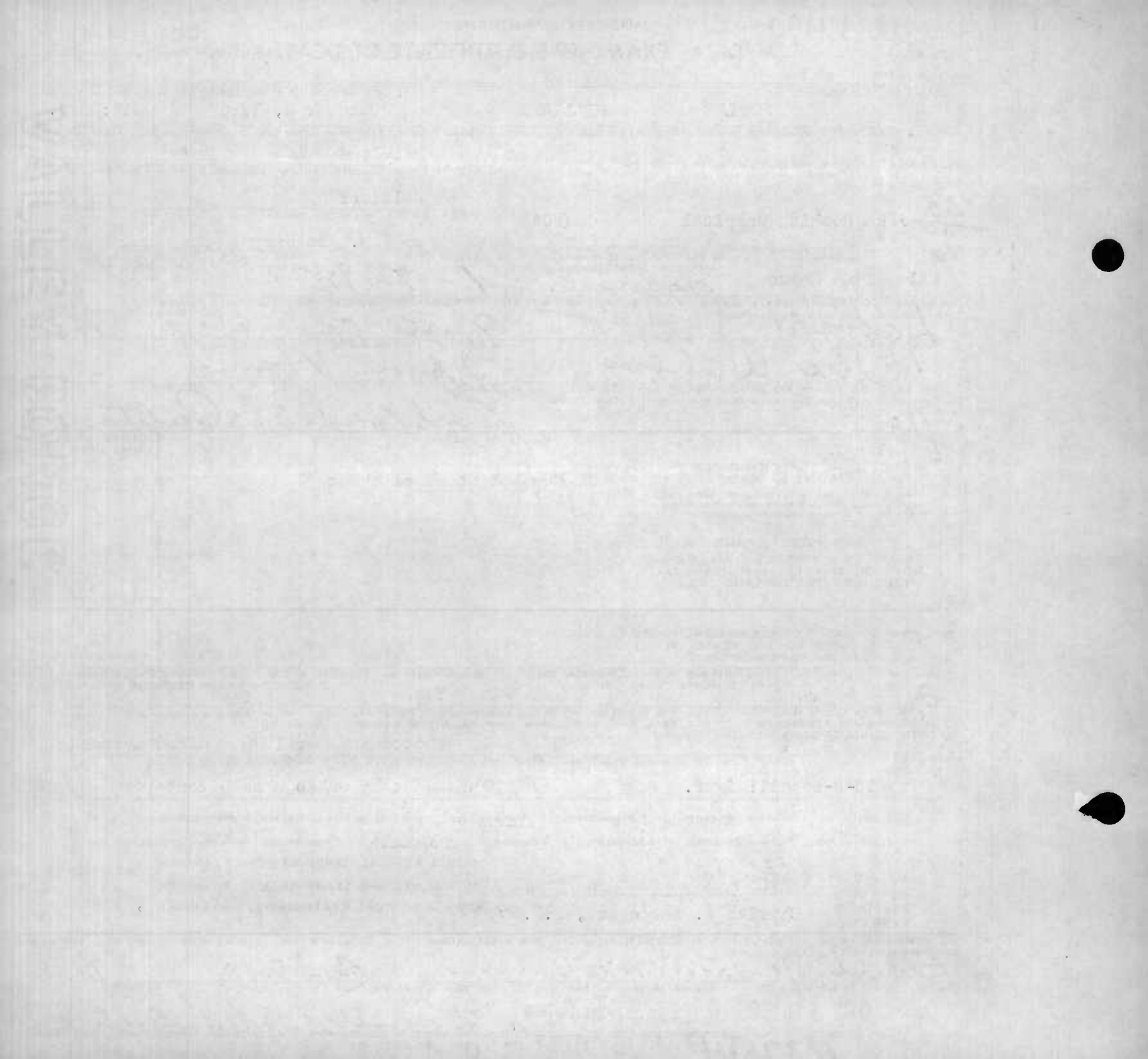
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Burnell S. Boden, Balto. Md.

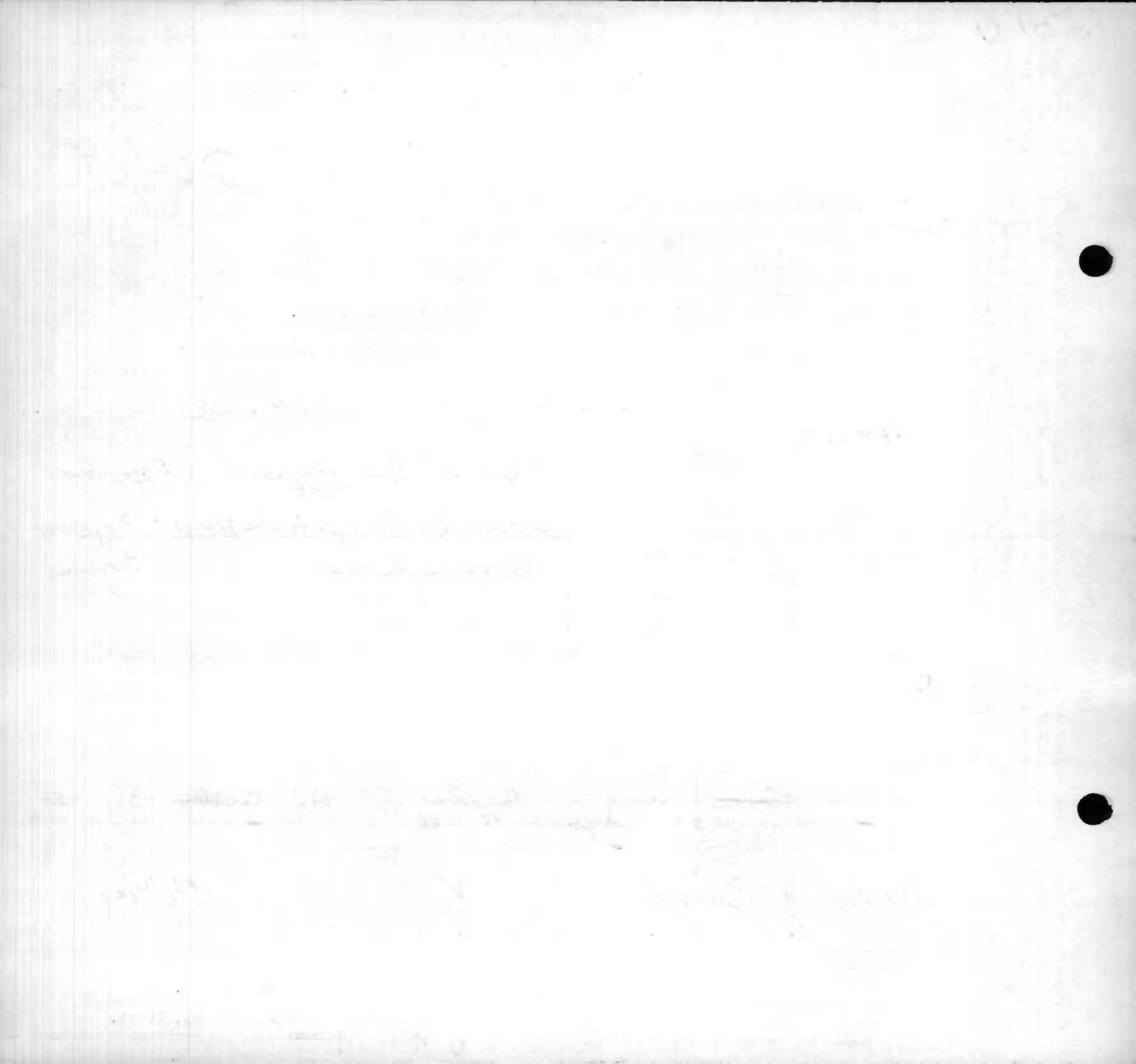
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <b>66 10401</b>	
BIRTH NO. <b>66 10401</b>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)		<b>IDA STAAB</b>						2. DATE AND HOUR OF DEATH		<b>Oct. 13, 1966   4:30 p. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION  <b>33 John Hopkins Hospital</b>		(If not in hospital or institution, give street address or location)						A. STATE <b>Md., 21213</b>		B. COUNTY	
								C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		<b>26-03</b>	
								D. STREET ADDRESS (If rural, give location) <b>3510 Elmley Avenue</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED <b>widowed</b>		8. DATE OF BIRTH <b>3/14/1896</b>		9. AGE (In years last birthday) <b>70</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Martin Nowak</b>				14. MOTHER'S MAIDEN NAME <b>Mary Anne Jankowska</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-28-6515 D</b>		17. INFORMANT <b>Bernard Staab, son, 4213 Antenna Ave.,</b>				ADDRESS <b>21206</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cerebral Hemorrhage</b> DUE TO (B) <b>Cardio-Vascular Hypertensive Disease - 3 years</b> DUE TO (C) <b>Arteriosclerosis</b> 3 years						INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>October 1963</b> to <b>October 13, 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>September 30, 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Michael J. Dausch</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/14/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Michael J. Dausch</b>						23D. ADDRESS <b>4636 Belair Road</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/17/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>				ADDRESS <b>3331 Brehms Lane</b>	

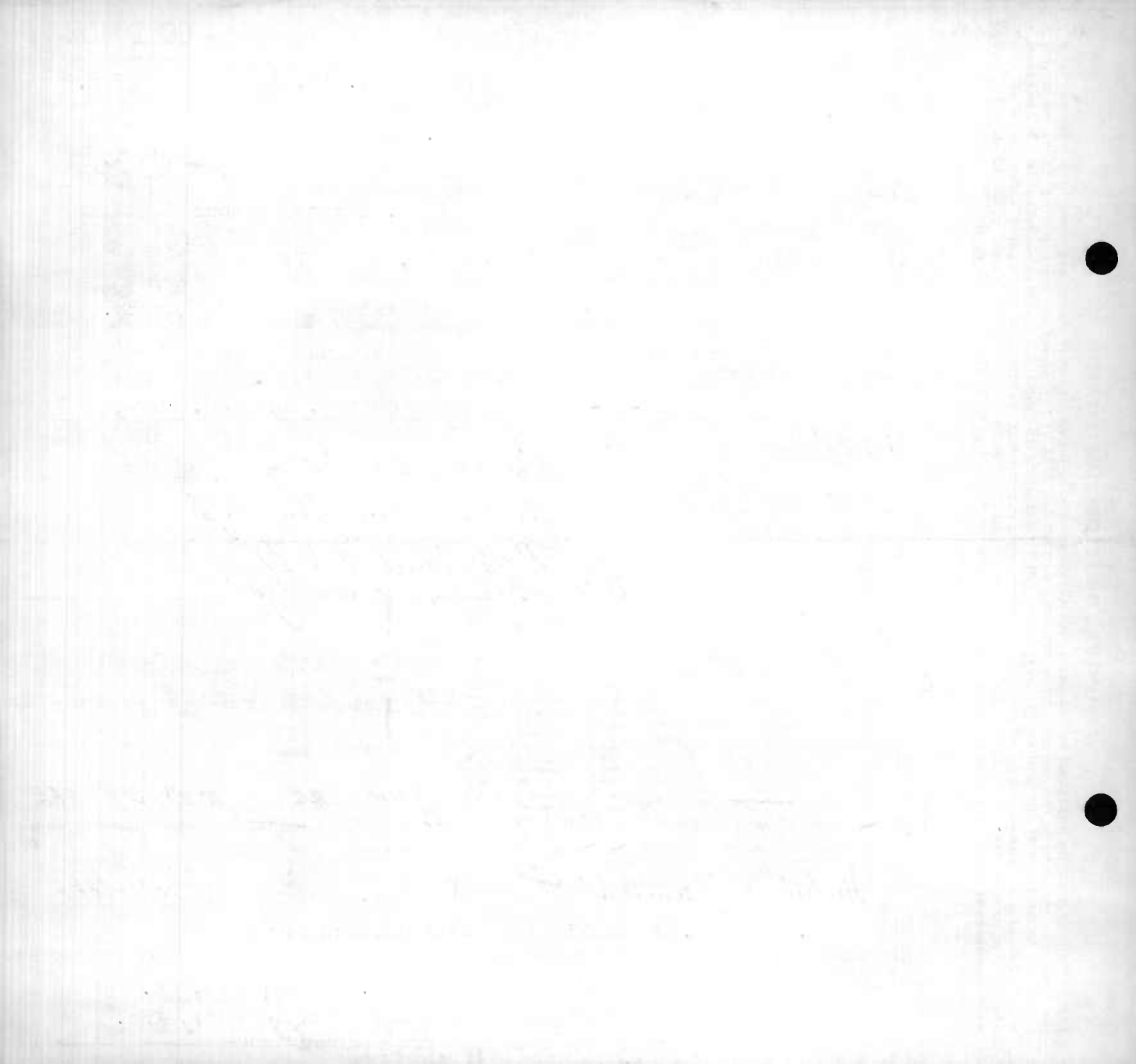


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		66 10402		CERTIFICATE OF DEATH			Registered No. <span style="float: right;">66 10402</span>		
M.E. CASE NO.				1. NAME OF DECEASED			2. DATE AND HOUR OF DEATH		
(Type or Print)				MARY GATTUS			Oct. 12, 1966   7 a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND							4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)					A. STATE		B. COUNTY
35 Church Home Hospital							Md. 21224		
							C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
							Baltimore		
							D. STREET ADDRESS (If rural, give location)		
							714 S. Luzerne Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
female	white	married		May 26, 1889	77				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
housewife			at home		Czechoslovakia		Czech.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Ferencin				unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				217-16-8690A		Steven Gattus, husband, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO					
				(B) DUE TO					
				(C) DUE TO					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Oct 1966, that (I) (we) last saw the deceased alive on Oct. 1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Melvin J. Jaworski M.D.						10/14/66			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
Dr. Melvin J. Jaworski M.D.						2711 Eastern Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		10/15/66		Sacred Heart of Mary Cem.		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 17 1966		Robert E. Farkas, M.D.		Schimunek Funeral Home, Inc.		3331 Brehms Lane			



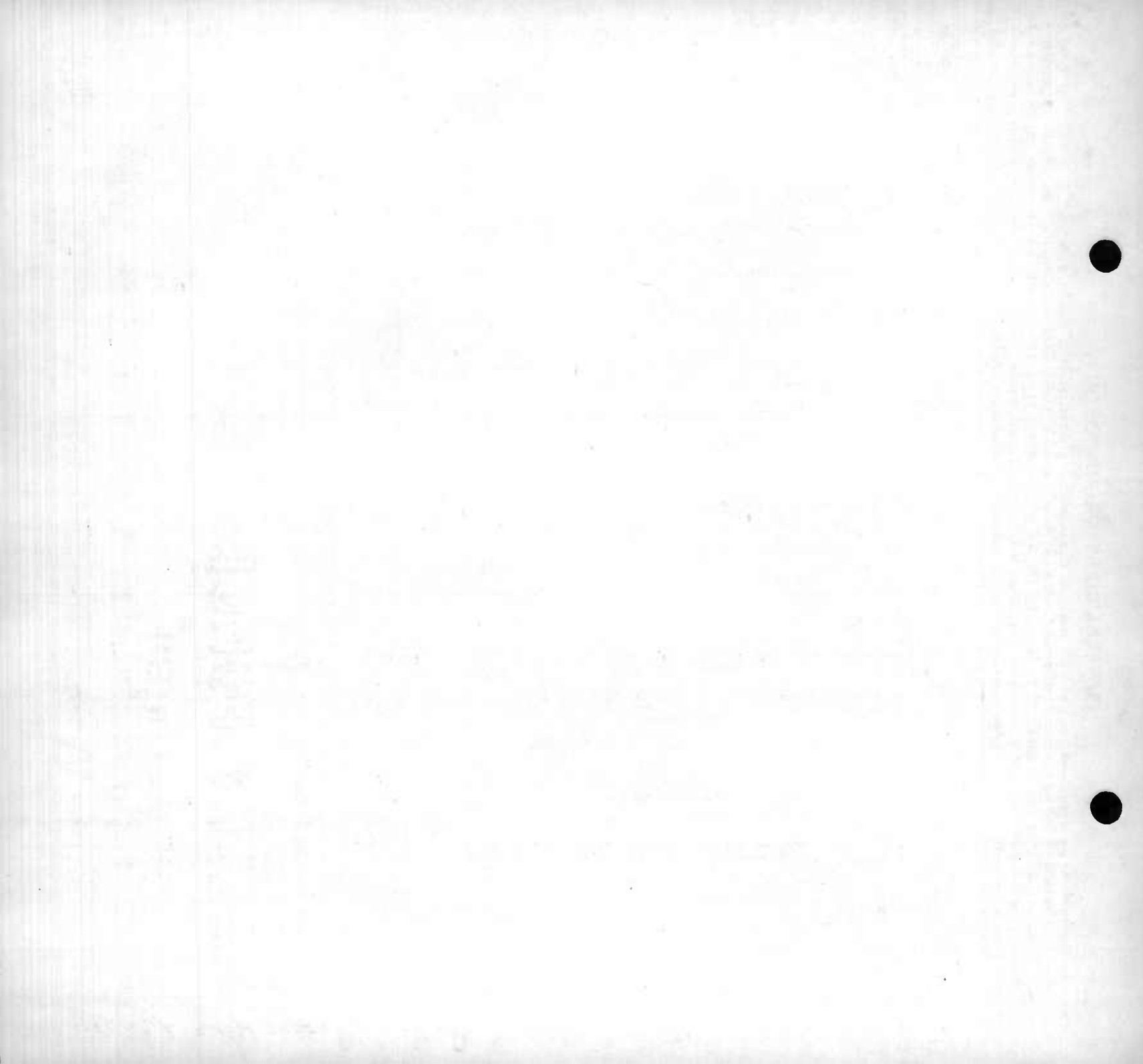




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

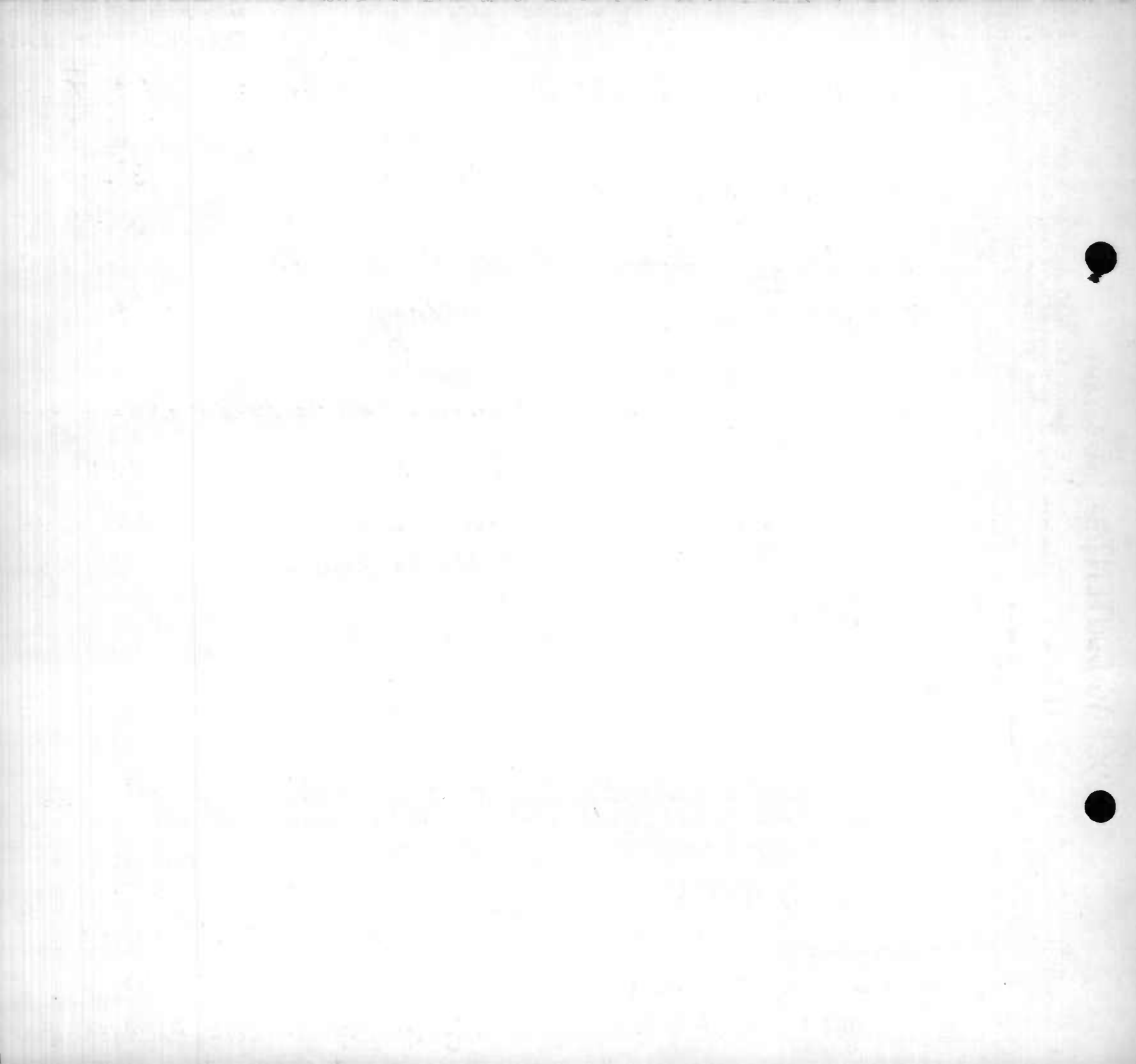
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10403</b>	
BIRTH NO. <b>66 10403</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Spencer Edward Louis</b>		2. DATE AND HOUR OF DEATH <b>10-13-66</b> <b>2:00</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>36 Franklin Square Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1815 Dundalk Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>5-10-97</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Andrew Spencer.</b>		14. MOTHER'S MAIDEN NAME <b>Alice Burns.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>216 10 4117</b>		17. INFORMANT <b>Hospital chart.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Congestive heart failure</b> <b>Probably due to Emphysema &amp; ASCVD.</b>		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Oct. 6</u> 19 <u>66</u> to <u>Oct. 13</u> 19 <u>66</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Oct. 13</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>Ki Bum Lee</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct. 13 '66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ki Bum Lee</b>		23D. ADDRESS <b>Franklin Square Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/17/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>COLGATE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME</b>			
25D. ADDRESS <b>DUNDALK MD</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

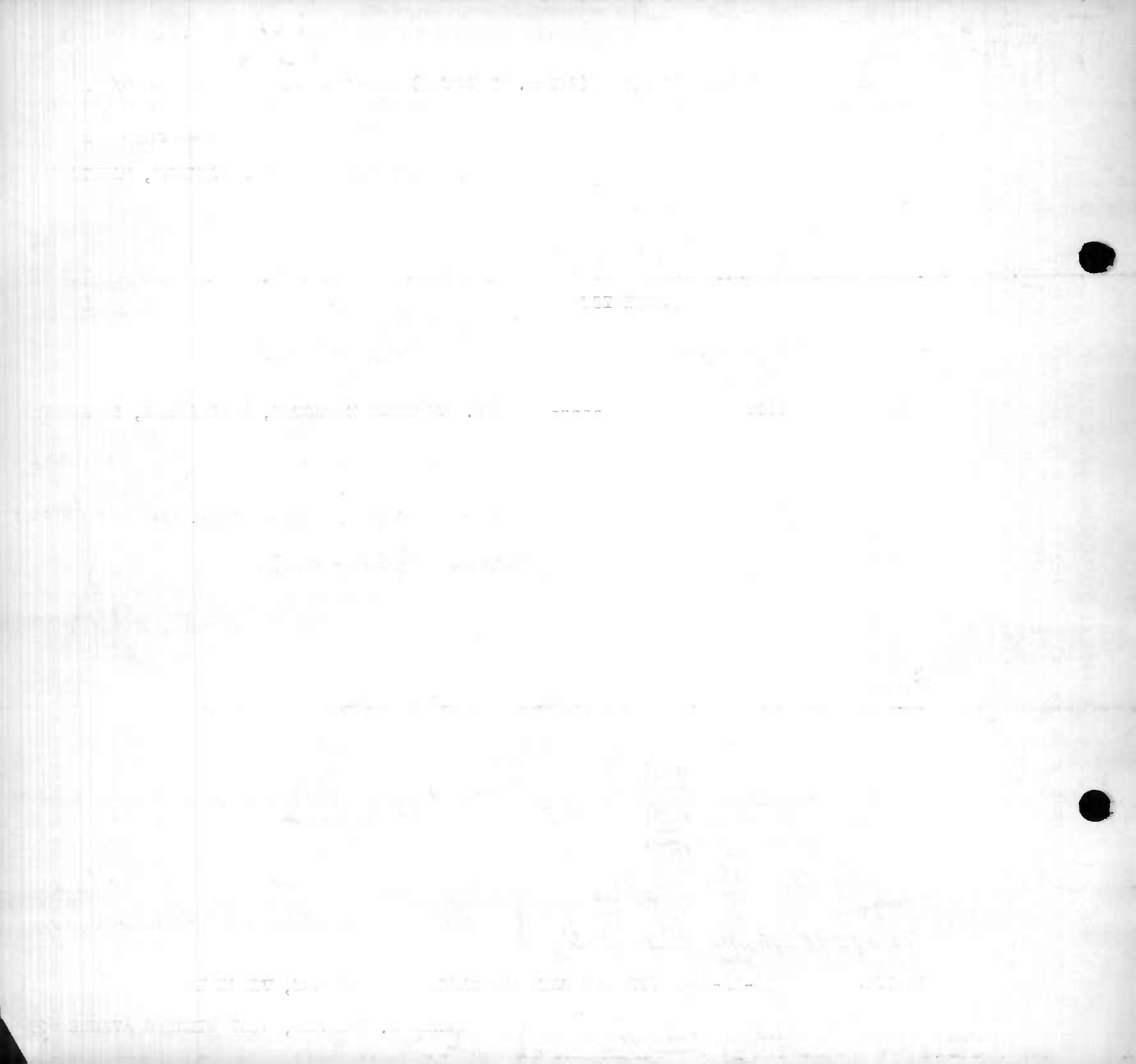
Baltimore City Health Department				Registered No. 66 10404	
BIRTH NO. 66 10404		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Meredith Dicea M</i>		2. DATE AND HOUR OF DEATH <i>13 Oct 66 655 A</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Fayette Convalescent Home</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>Balt Co.</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>DUNDALK 53-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>11 Datebrook Dr 1916 MAXWELL</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>OCT 15 1891</i>	9. AGE (In years lost birthday) <i>75 74</i>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AT HOME</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>INDIANA</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>313-30-6379</i>		17. INFORMANT <i>OLIVER L. MEREDITH 1916 MAXWELL AVE</i>	
18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>Uremia</i> DUE TO (B) <i>C.V.P. Dis</i> DUE TO (C) <i>Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>several mos.</i> <i>" yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Rt leg amputee (1962)</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>500</i> <i>19 66</i> to <i>13 Oct 1966</i> , that (I) (we) last saw the deceased alive on <i>13 Oct 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Hulla</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>13 Oct 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. Hulla</i>		23D. ADDRESS <i>2214 E Fayette St 21231</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/17/66</i>		24C. NAME of CEMETERY or CREMATORY <i>MEADOW RIDGE PARK</i>	
24D. LOCATION <i>DORSEY MD</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>VULFISH FUNERAL HOME DUNDALK MD</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 2em;">X</span> 66 10405	
BIRTH NO. <span style="font-size: 2em;">66 10405</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">Guy Thurston</span> (GUY E. THURSTON)		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">10/12/66 12:35 AM</span> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">43 SOUTH Baltimore GENERAL Hospital</span>		A. STATE <span style="font-size: 1.5em;">MARIAND</span> B. COUNTY <span style="font-size: 1.5em;">Howard Co. 63-00</span>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">GIBBSVILLE XXXXXXXXXX DANIELS, MARYLAND</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.5em;">Box 37</span>			
5. SEX <span style="font-size: 1.5em;">M</span>	6. RACE <span style="font-size: 1.5em;">Cauc-</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.5em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.5em;">11/29/96</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">69</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Retired</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">MACHINIST</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Virginia</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.5em;">Elmer Thurston</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Dora Wood</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">XXXX</span>		17. INFORMANT ADDRESS <span style="font-size: 1.5em;">MR. LAWRENCE THURSTON, 4 BROADWAY, PASADENA</span>	
18. <span style="font-size: 1.5em;">600.0 I</span>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <span style="font-size: 1.5em;">Septicemia</span> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">4-5 hrs</span></span>			
ANTECEDENT CAUSES		(B) DUE TO <span style="font-size: 1.5em;">Acute &amp; Chronic Renal disease</span> <span style="float: right;">4 years</span>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <span style="font-size: 1.5em;">Chronic Pyelonephritis</span> <span style="float: right;">"</span>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.5em;">ASCUD</span>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>we</del> (this hospital) attended the deceased from <span style="font-size: 1.5em;">10/12</span> 19 <span style="font-size: 1.5em;">66</span> to <span style="font-size: 1.5em;">10/12</span> 19 <span style="font-size: 1.5em;">66</span> , that <del>we</del> (we) lost saw the deceased alive on <span style="font-size: 1.5em;">10/12</span> 19 <span style="font-size: 1.5em;">66</span> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Stephen Namoff</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.5em;">10/12/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Stephen Namoff, M.D.</span>		23D. ADDRESS <span style="font-size: 1.5em;">SOUTH Baltimore General Hosp.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">BURIAL</span>		24B. DATE <span style="font-size: 1.5em;">10-15-66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.5em;">ROCKGATE CEMETERY</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">CROZET, VIRGINIA</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 17 1966</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Howard H. Hubbard</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.5em;">HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10406		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10406	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>CARR, MARY R. Bateman, Mary R.</i>		2. DATE AND HOUR OF DEATH <i>October 14, 1966 1 700 A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hospital</i>		A. STATE <i>Maryland</i>			
38		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>514 West Fayette St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>3/18/1888</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Roseby Carr</i>		14. MOTHER'S MAIDEN NAME <i>Jane Lancaster</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>213-54-2329</i>		17. INFORMANT ADDRESS <i>Chart University Hosp.</i>	
18. <i>170 X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>metastatic Carcinoma of breast</i>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(I)</del> (this hospital) attended the deceased from <i>Oct 14</i> 1966 to <i>Oct 14</i> 1966, that (I) <del>(we)</del> lost saw the deceased alive on <i>Oct 14</i> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Anne C. Colston</i> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/14/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Anne C. Colston</i>		23D. ADDRESS <i>University Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/17/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cockhart Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Cockhart, Anne Arundel, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1966</i>		24F. NAME OF REGISTRAR <i>Robert E. Folsom</i>	
24G. FUNERAL DIRECTOR <i>John J. Brown &amp; Son, Inc.</i>		24H. ADDRESS <i>901 Hollis St. 232nd.</i>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10407		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10407	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 66 10407	
1. NAME OF DECEASED (Type or Print) <i>Leader, Betty R.</i>		2. DATE AND HOUR OF DEATH <i>10/13/66</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>330</i>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Owings Mills</i> D. STREET ADDRESS (If rural, give location) <i>Box # 53-00</i> <i>Deer Park Road. 353</i>		FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Baltimore</i>		(If not in hospital or institution, give street address or location)	
5. SEX <i>Fe.</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>12/15/38</i>	9. AGE (In years lost birthday) <i>36</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Exec.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>BTO. R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE</i>	
13. FATHER'S NAME <i>BACKUS, Thomas C. Sr.</i>		14. MOTHER'S MAIDEN NAME <i>WOLF, Gertrude R.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218-26-5403</i>		17. INFORMANT <i>HUSBAND: MYRON</i>	
18. <i>330X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <i>Subarachnoid hemorrhage. 48hrs.</i> DUE TO (B) <i>Hypertensive cerebrovascular disease.</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>36-48hrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonia + Bronchopneumonia.</i>		19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>10/14/66</i> 19 to <i>10/13</i> 19 <i>66</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>10/13</i> 19 <i>66</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Erwin H. Hesselberg</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/13/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Erwin H. Hesselberg</i>		M.D.		23D. ADDRESS <i>Sinai Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-15-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Evergreen Memorial Pl.</i>	
24D. LOCATION (City, town, or county) (State) <i>Carroll Co. Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1966</i>		25B. NAME OF REGISTRAR <i>Phyllis E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Erwin H. Hesselberg</i>		ADDRESS <i>8728 Lytle Rd. Randallstown, Md</i>			

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J. M. H. H. H.

1871

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10408		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10408	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM A. DOENGES</b>			2. DATE AND HOUR OF DEATH <b>Oct. 13, 1966</b>   <b>7 28</b> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balt. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>53-00</b> <b>2816 Wells Rd.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>06/06/90</b>	9. AGE (In years last birthday) <b>76</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED Barber</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>CONRAD DOENGES</b>			14. MOTHER'S MAIDEN NAME <b>SUSIE HARMAN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-2735</b>		17. INFORMANT ADDRESS <b>ONETA FORREST 2816 Wells Rd.</b>	
18. <b>420.14-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>CORONARY THROMBOSIS</b> DUE TO (B) <b>CHRONIC OBSTRUCTIVE</b> DUE TO <b>AIRWAY DISEASE-SEVERE</b> (C) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE - 5 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>8-10 years</b> <b>3 MONTHS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus - MILD</b>					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(this hospital)</u> attended the deceased from <u>Oct 11</u> , 19 <u>66</u> to <u>Oct 13</u> , 19 <u>66</u> , that <u>(I)</u> <u>(we)</u> last saw the deceased alive on <u>Oct 13</u> , 19 <u>66</u> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>Nina Rawlings</b>				23B. DATE SIGNED <b>Oct 13, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>NINA RAWLINGS</b>		23D. ADDRESS M.D. <b>Md GENERAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-17-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balt. Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>8728 Liberty Rd. Randallstown, Md.</b>			

MARYLAND GENERAL HOSPITAL

MAJ. WALTER WIDEN

3547 1/2

CONRAD TOWNS

No

11247

12/1/1945

2315 WILSON RD

01/04/46

MARYLAND

SUSIE MARGAN

NOV

44-11-1000 DUSTY FOREST 2315 WILSON

CORONARY THROMBOSIS 1 HX

CHRONIC OBSTRUCTIVE  
AIRWAY DISEASE SEVERE

ARTERIAL HYPERTENSION

URINARY TRACT - HX

No

NO

Oct 14

Oct 11

Oct 10

Wm. K. Kung

MD. GEN. HOSP.

MD. GEN. HOSP.

Oct 8

FUNERAL DIRECTOR: IMPORTANT

10 13 66

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. — 66 10409	
BIRTH NO. <b>66 10409</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <b>66 10409</b>					
1. NAME OF DECEASED (Type or Print) <b>BECKIE FOX</b>		2. DATE AND HOUR OF DEATH <b>10-13-66 10:45 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		A. STATE <b>MARYLAND</b>			
(If not in hospital or institution, give street address or location)		B. COUNTY			
<b>33</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>3840 OAKFORD AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) MARRIED</b>	8. DATE OF BIRTH <b>7-18-92</b>	9. AGE (In years lost birthday) <b>74</b>	(If Under 1 Yr. Months: Days: Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
13. FATHER'S NAME <b>HARRY NUDELMAN</b>		14. MOTHER'S MAIDEN NAME <b>MINICHE BUSUK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>HOSP. RECORDS</b>	
18. <b>002,1 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>bilateral pulmonary infiltrate</b> DUE TO			
ANTECEDENT CAUSES		(B) <b>probably 2° to the</b> DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>chronic renal disease</b>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>chronic renal disease</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (M) (this hospital) attended the deceased from <b>Oct 8</b> 19 <b>66</b> to <b>Oct 13</b> 19 <b>66</b> , that (W) (we) last saw the deceased alive on <b>Oct 13</b> 19 <b>66</b> and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above. (M) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Monica M. Buckley</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/13/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MONICA M. BUCKLEY</b>		23D. ADDRESS <b>1620 McElderry St</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/14/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Windsor Hill Rd</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SYLVAN S. LEWIS &amp; SON - 3319 OLYMPIA AVE</b>			

1000

1000

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1000

66 10410

BALTIMORE CITY HEALTH DEPARTMENT

66 10410

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ARSEE

W.

WATSON

2. DATE AND HOUR PRONOUNCED DEAD

October 12, 1966

4:45 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

936 N. Chapel Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

936 N. Chapel Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

3-15-1916

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

Crown, Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin Watson

14. MOTHER'S MARRIED NAME

Lettie Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

224-26-7934

17. INFORMANT

ADDRESS

Mrs. Lillie Moore 1812 E. Faber St.

18.

443X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertensive Heart Disease.  
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
10/13/6623A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-15-66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cmty.

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 17 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS



WALTER  
PACIFIC  
COAST  
LUMBER  
CO.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 10411</u>	
BIRTH NO. <u>66-19493</u> <u>66 10411</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL SCHUMAN</b>				2. DATE AND HOUR OF DEATH <b>SEPT. 5, 1966 4:40P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>Balts. Co.</b>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>4221 TWIN CIRCLE WAY</b>					
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>CHILD</b>		8. DATE OF BIRTH <b>9/05/66</b>	
9. AGE (In years last birthday)		10. AGE (In years last birthday)		11. Under 1 Yr. Months Days		12. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>			
11. BIRTHPLACE (State or foreign country) <b>ST. AGNES HOSPITAL BALTIMORE, MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>LEE WARREN SCHUMAN</b>				14. MOTHER'S MAIDEN NAME <b>DIANA WARREN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>HOSPITAL SLIP-CATON &amp; WILKENS AVENUES</b>				ADDRESS			
18. <b>776 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Immaturity</b>				CAUSE OF DEATH			
19. <b>776 X I</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from <b>SEPT. 5, 3:40P</b> 19 <b>66</b> to <b>SEPT. 5, 4:40P</b> 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>SEPTEMBER 5,</b> 19 <b>66</b> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE <i>Joza M. Boyd</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOZA M BOYD</b>				23D. ADDRESS <b>BALTO., MD. 21229</b> <b>ST. AGNES HOSPITAL-CATON &amp; WILKENS AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/14/66</b>		24C. NAME of CEMETERY or CREMATORY <b>NEW CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Fabela</i>		25C. FUNERAL DIRECTOR <b>H. W. MEARS &amp; SON</b>		ADDRESS <b>805 N. CALVERT ST.</b>	

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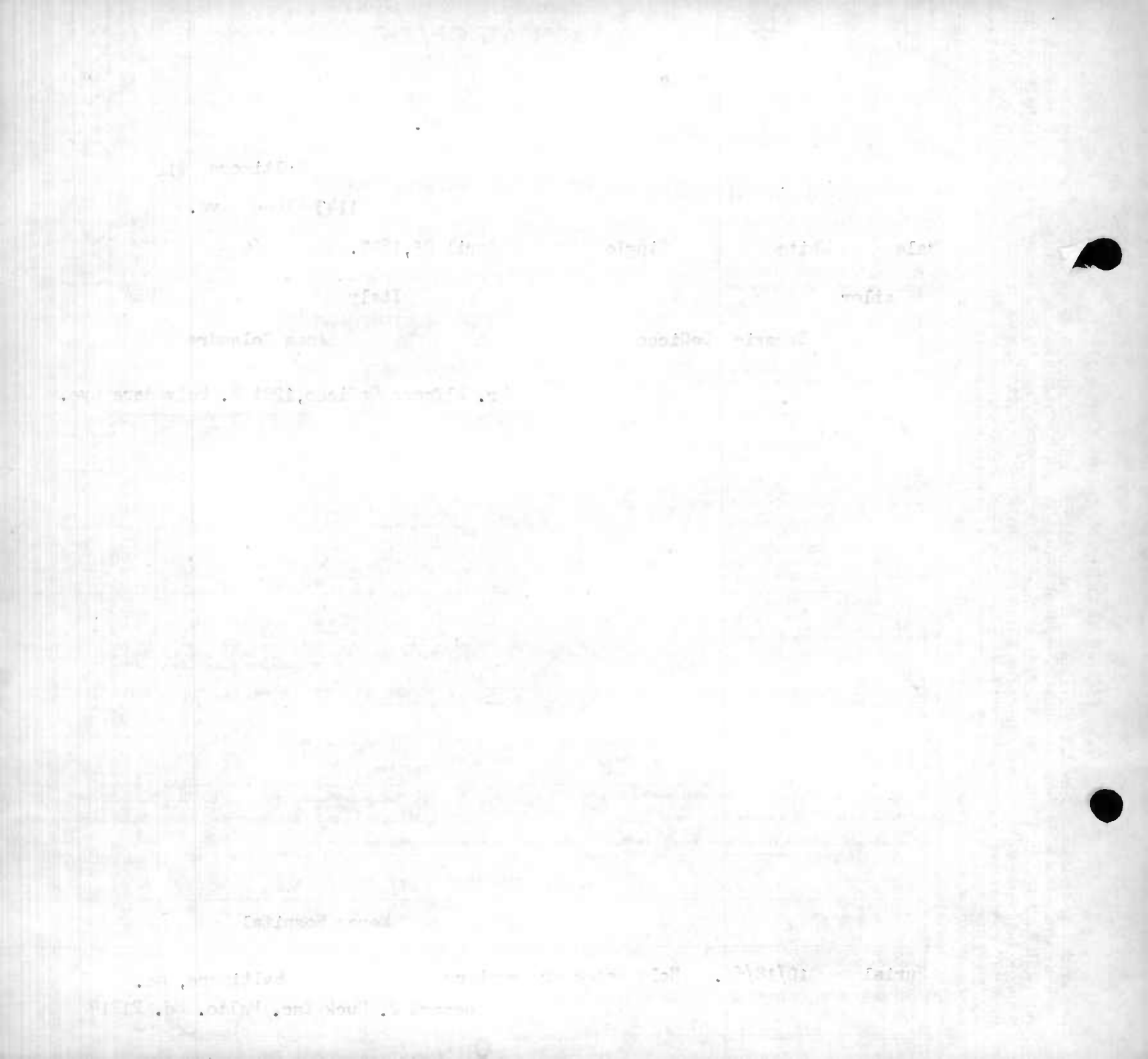
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

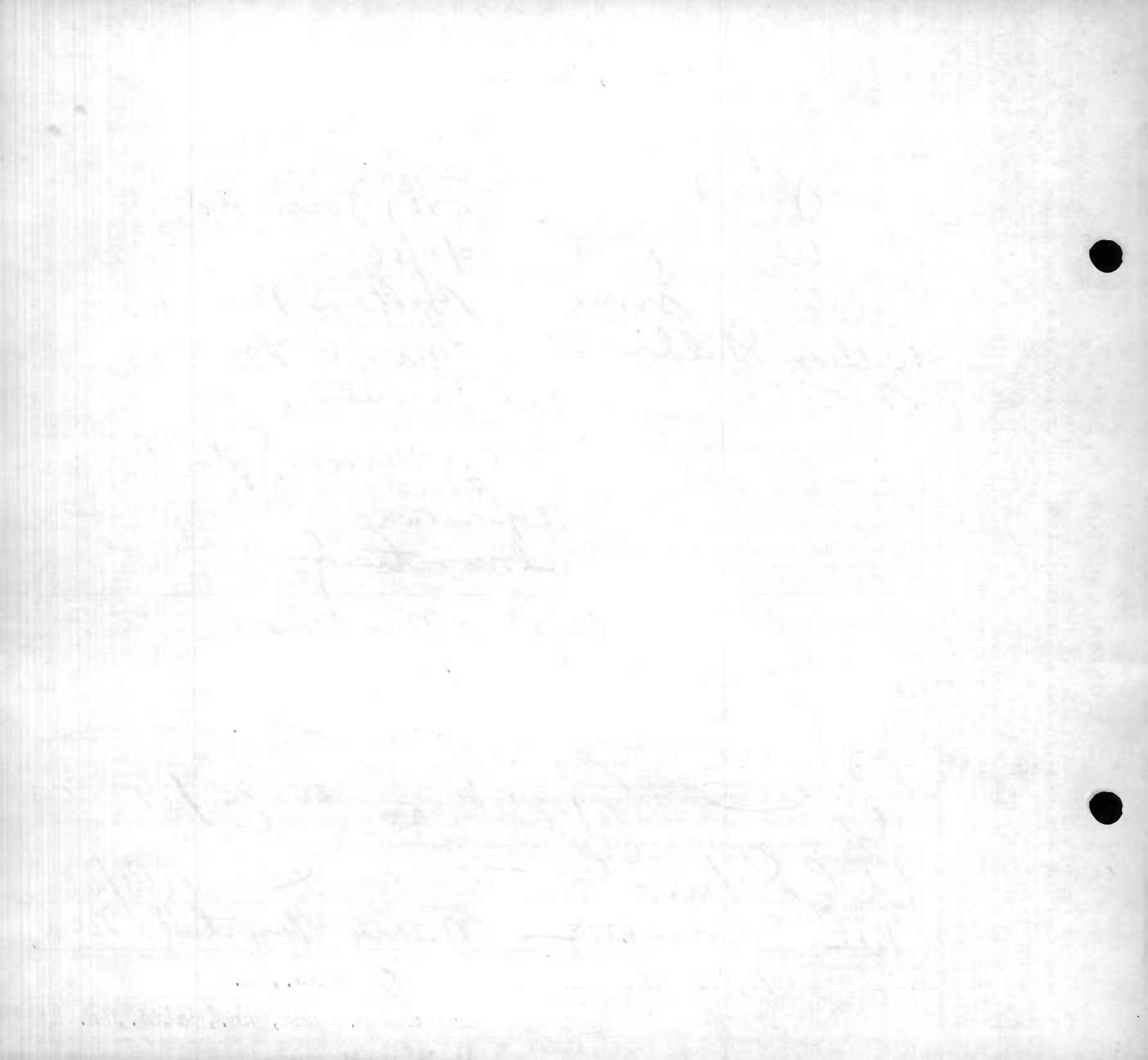
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10412	
BIRTH NO. 66 10412					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Jerome DeCicco</i>			2. DATE AND HOUR OF DEATH <i>10-14-66 1 9<sup>10</sup> P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 Mercy Hosp.</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-38</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #12</i>		
			D. STREET ADDRESS (If rural, give location) <i>1143 Elbank Ave.</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>April 25, 1897.</i>	9. AGE (In years lost birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Saverio DeCicco</i>			14. MOTHER'S MAIDEN NAME <i>Anna Colandre</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mr. Alfonso DeCicco, 1201 E. Belvedere Ave.</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Cardiac Arrest</i> DUE TO (B) <i>Complete Atrio dissociation</i> DUE TO (C) <i>Acute Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2</i> <i>1</i> <i>1</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-14-66</i> to <i>10-14-66</i> , that (I) (we) last saw the deceased alive on <i>10-14-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B Venkatachalam</i> M.D.			23B. DATE SIGNED <i>10-14-66</i>		23C. PHYSICIAN'S NAME (Type) <i>B. Venkatachalam</i> M.D.
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>10/18/66.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1966</i>		
25B. NAME OF REGISTRAR <i>Leonard J. Ruck Inc.</i>			25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10413		CERTIFICATE OF DEATH		Registered No. 66 10413	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Sheldon, Mary Rita		2. DATE AND HOUR OF DEATH 10/14/66 17 <sup>15</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: Baltimore C. CITY OR TOWN: Baltimore D. STREET ADDRESS: 5501 Jones Rd			
5. SEX: M	6. RACE: W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M	8. DATE OF BIRTH: 10/11/66	9. AGE (In years lost birthday): 23	10. Under 1 Yr. Months: 3 Days: 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn		10B. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Baltimore Md	
12. CITIZEN OF WHAT COUNTRY: USA		13. FATHER'S NAME: William J. Sheldon III		14. MOTHER'S MAIDEN NAME: Mary C. London	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No		16. SOCIAL SECURITY NO.: none		17. INFORMANT: Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO: Central Nervous System bleed (B) DUE TO: Aspiration (C) DUE TO: Immaturity		INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 hours	
19A. DATE OF OPERATION: none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: none		20A. AUTOPSY? (Yes or No): no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): none	
21D. TIME OF INJURY (APPROX.): none		21E. INJURY OCCURRED: While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?: none	
22. I certify that (I) (this hospital) attended the deceased from 10/11/66 to 10/14/66, that (I) (we) last saw the deceased alive on 10/14/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE: W.E. Schwartz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED: 10/14/66	
23C. PHYSICIAN'S NAME (Type): W.E. SCHWARTZ		23D. ADDRESS: Mercy Hospital Md			
24A. BURIAL CREMATION, REMOVAL (Specify): Burial		24B. DATE: 10/17/66		24C. NAME OF CEMETERY or CREMATORY: Holy Redeemer Cemetery Balto., Md.	
24D. LOCATION (City, town, or county) (State): Balto., Md.		25A. DATE REC'D BY HEALTH DEPT.: OCT 17 1966		25B. NAME OF REGISTRAR: Robert E. Farley	
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc., Balto., Md.		25D. ADDRESS: 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10414		CERTIFICATE OF DEATH		Registered No. 66 10414	
1. NAME OF DECEASED (Type or Print) <b>Florence Winifred Miller</b>				2. DATE AND HOUR OF DEATH <b>z October 14th 1966</b> arrived <b>8:10AM</b> Exp <b>10:5 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Saint Agnes Hospital</b> <b>40 Caton &amp; Wilkens Aves. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3427 Northway Drive</b> <b>40ne 34</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/18/09</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ralph M. Folwell</b>				14. MOTHER'S MAIDEN NAME <b>Edna Thompson</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Charles L. Miller</b>		ADDRESS <b>Same</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>5-02-01</b> <b>Hemorrhage from artery</b> <b>Brain due to Hypertension</b> <b>essential Hypertension</b> <b>Chronic Pulmonary emphysema</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>July 1 1950</b> to <b>Oct 14 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 15 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
23A. SIGNATURE <b>Donald W. Mintzer</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Oct 14 1966</b>					
23C. PHYSICIAN'S NAME (Type) <b>Donald Mintzer (CL-5227)</b>				23D. ADDRESS <b>3009 EVERGREEN AVE.</b> <b>BALTIMORE MD 21214</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/19/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Phipps Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Clarion County, Pennsylvania</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>John E. Talbot</b>		25C. FUNERAL DIRECTOR <b>Leonard O. Ruck, Inc., Balto., Md. 21214</b>					



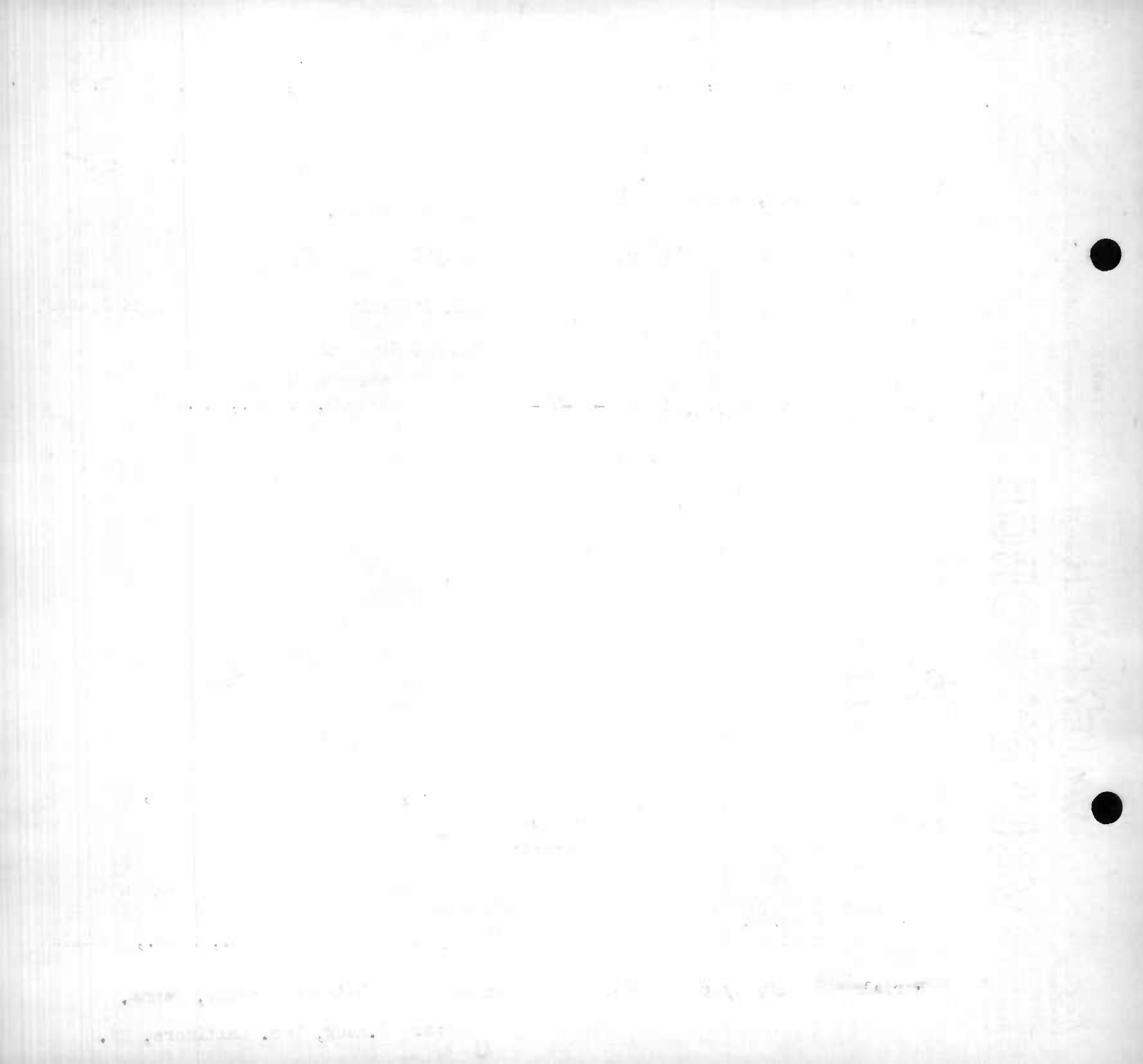




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

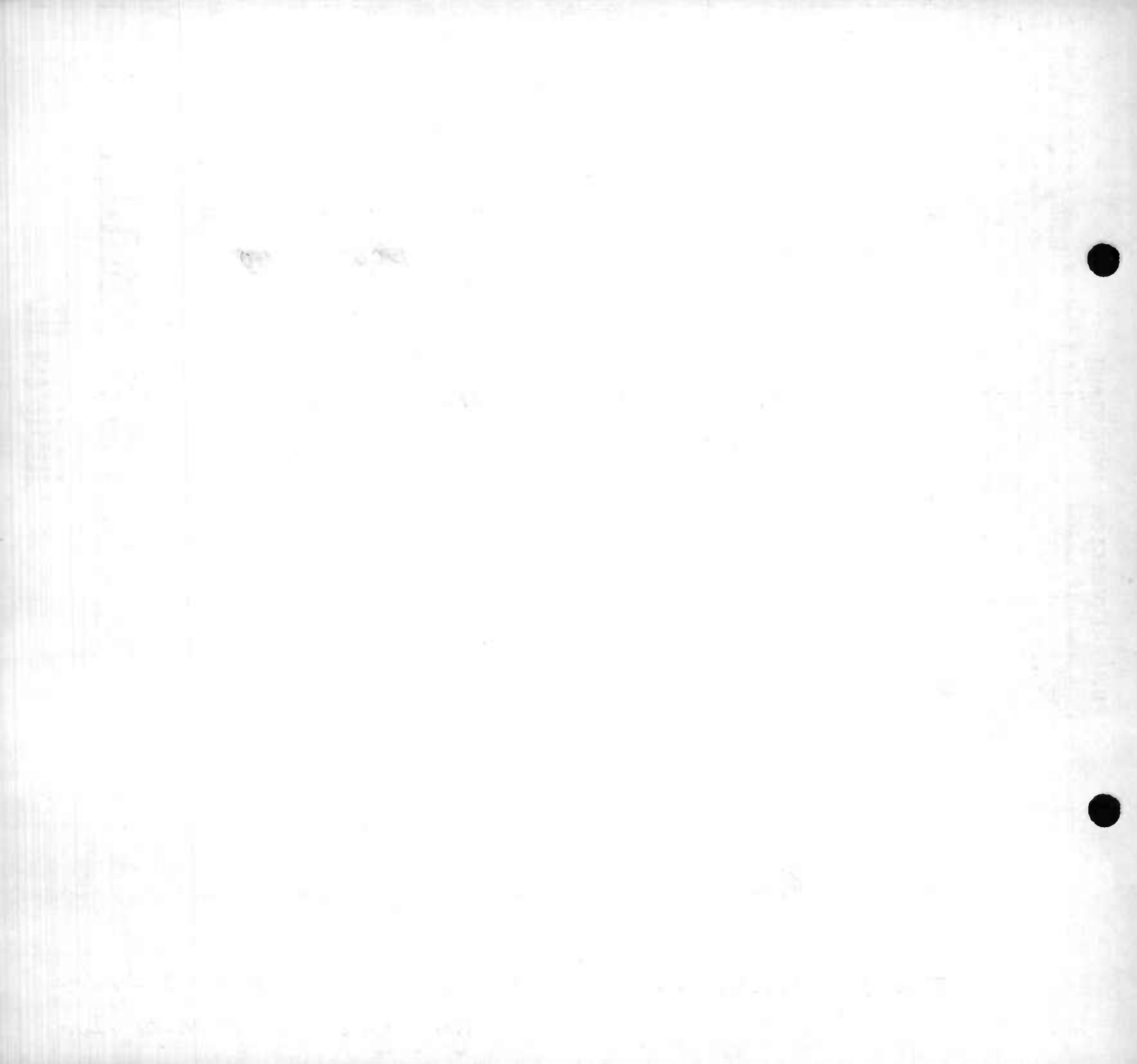
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10415</b>	
BIRTH NO. <b>66 10415</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Rementer, William Louis</b>			2. DATE AND HOUR OF DEATH <b>October 14, 1966 12:05 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>Philadelphia</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Philadelphia</b>		
			D. STREET ADDRESS (If rural, give location) <b>117 Dudley St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>1/5/92</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rubbish Collector</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>John Rementer</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Hamilton</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 9/22/17 to 5/10/19</b>		16. SOCIAL SECURITY NO. <b>185-01-29-18</b>	17. INFORMANT <b>Veterans Hospital</b> ADDRESS <b>Records, Balto., Md. 21218</b>		
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic Carcinoma</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location <b>Yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>September 20, 1966</b> to <b>October 14, 1966</b> , that <del>(H)</del> (we) last saw the deceased alive on <b>October 14, 1966</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(H)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>Ralph H. Twining</b>				23B. DATE SIGNED <b>10/14/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RALPH H. TWINING</b>		23D. ADDRESS M.D. <b>VAH 3900 Loch Raven Blvd., Balto., Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/18/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Fernwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Delaware County, Penna.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Baltimore, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-42		BIRTH NO. 66 10416		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10416	
1. NAME OF DECEASED (Type or Print) <b>MINNIE WILKERSON</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 17, 1966   5:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTIMORE</b> <b>42</b>				A. STATE <b>MARYLAND</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>15-48</b>			
				D. STREET ADDRESS (If rural, give location) <b>2309 ROSLYN AVE. #16</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>MAY 2, 1906</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>LINDY KREETCH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. SAMMY KREETCH</b>		ADDRESS <b>1518 Smallwood, etc</b>
18. <b>181.0 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>CARCINOMA OF THE BLADDER</b> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>9/13/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>METASTATIC CARCINOMA OF BLADDER</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 31 1966</b> to <b>OCTOBER 17 1966</b> , that (I) (we) lost the deceased alive on <b>OCTOBER 17 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Francisco D. Sabado, Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>October 17, 1966</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/20/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Beulah Baptist Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Bell Dot South Carolina</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm S. Marsh</b>		ADDRESS <b>928 E. North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10417	
BIRTH NO. 66 10417		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MIRIAM LAU SIEGMUND		2. DATE AND HOUR OF DEATH October 14, 1966 1:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION residence: 00 3017 Weaver Ave.		D. STREET ADDRESS (If rural, give location) 3017 Weaver Avenue			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Oct. 8, 1901	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sharpsburg, Pa.	
13. FATHER'S NAME Dr. S. J. McDowell		14. MOTHER'S MAIDEN NAME Anna Lau		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT C. Gordon Siegmund ADDRESS 3017 Weaver Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		CAUSE OF DEATH Cardiac Arrest 10/14/66 (A) DUE TO (B) DUE TO (C) Coronary Thrombosis 3 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10/14/66	
19A. DATE OF OPERATION 10/17/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/12/66 19 to 10/14/66 1966, that (I) (we) last saw the deceased alive on 10/12/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Walter E. Karfigin		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/14/66	
23C. PHYSICIAN'S NAME (Type) Dr. Walter E. Karfigin		23D. ADDRESS 4331 Harford Rd., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 10/17/66		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore		24E. LOCATION Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Leonard J. Ruek, Inc.		25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd., 14	

October 12, 1900

Dear Sir

Bellevue

1111 Beaver Avenue

St. Louis

Oct. 12, 1900

My dear Sir

10

Bellevue

St. Louis

Dear Sir

Bellevue

London Station

St. Louis

Bellevue

10

Bellevue

St. Louis

Bellevue

St. Louis

Bellevue

Bellevue

BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 60 10418

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>FRANCES M. MOORE</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>October 14, 1966 10:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>1633 Sherwood Avenue</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>27-38</b> D. STREET ADDRESS (If rural, give location) <b>1633 Sherwood Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>1-14-1886</b>	9. AGE (In years last birthday) <b>79 80</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Matthews Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Moore</b>			14. MOTHER'S MAIDEN NAME <b>Julia Dutton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-05-9014</b>		17. INFORMANT ADDRESS <b>George L. Moore, Same</b>		
18. <b>422.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) DUE TO  (B) DUE TO  (C) DUE TO  INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenecker</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/14/66</b>		
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>10/17/66</b>		23C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		24C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md. 21214</b>		ADDRESS	

VALLEY FORGE

11/10

1-11-1918

1-11-1918

1-11-1918

1-11-1918

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1-11-1918



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10419

BIRTH NO. 66 10419

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES F. WESTFALL

2. DATE AND HOUR PRONOUNCED DEAD

October 16, 1966

6:33 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3101 Virginia Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan. 5, 1948

9. AGE (In years  
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Dry Wall Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Dry Wall

11. BIRTHPLACE (State or foreign country)

Clarksburg, W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Dorothy Doka

14. MOTHER'S MAIDEN NAME

James W. Westfall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

242-78-4045

17. INFORMANT

ADDRESS

Mr. J. W. Westfall, 3101 Virginia Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Craniocerebral trauma  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

driveway

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Coldspring Lane and Falls Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10-16-66 6:20 P. m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Left roadway and  
struck pole in Gulf Gasoline Station

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 17, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

20/20/66

23C. NAME OF CEMETERY or CREMATORY

Lake View Cemetery

23D. LOCATION

(City, town, or county)

(State)

Liberty Road, Carroll Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS  
4611 Park Heights Ave.

VALLEY

FOOTING

100

100

100

100

100

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100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 64 34833		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10420	
M.E. CASE NO. 66 10420		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BARBARA MAYNE K.		2. DATE AND HOUR OF DEATH 10-15-66		2.22 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-03 D. STREET ADDRESS (If rural, give location) 4400 DAYTONA AVENUE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) CHILD (NEVER MARRIED)	8. DATE OF BIRTH 12-5-64	9. AGE (In years lost birthday) 22 mos.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ROBERT E. MAYNE, SR.		14. MOTHER'S MAIDEN NAME FLOSSIE HELMICK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hosp. Rec.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO Ventricular fibrillation ANTECEDENT CAUSES (B) DUE TO probable myocardial infarction DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) congenital heart disease (common) Atrioventricular septal defect, deformed mitral valve II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 10-15-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Complete heart block		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-20-66 19 to Oct 15 19 66, that (I) (we) last saw the deceased alive on 10-15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE B. D. Lowery MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-15-66	
23C. PHYSICIAN'S NAME (Type) B.D. LOWERY		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/18/66		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Dorsey, Howard County, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 17 1966		25B. NAME OF REGISTRAR J. E. Eschman	
25C. FUNERAL DIRECTOR ADDRESS 4611 Park Heights Ave.		25D. NAME OF REGISTRAR J. E. Eschman			

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Part I

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BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 66 10421		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10421	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>HARRY STEWART</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 14, 1966 1:20 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>0016 S. Spring St</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>16 S Spring St</b>	
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Sept 25, 1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired Laborer</b>	9. AGE (In years last birthday) <b>72</b>
11. BIRTHPLACE (State or foreign country) <b>Bald. Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Parker Stewart</b>		14. MOTHER'S MAIDEN NAME <b>Laura?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes World War #1</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Thelma Moody</b>		ADDRESS <b>200 N. Conquist St</b>	
18. CAUSE OF DEATH <b>381.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cirrhosis of Liver</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Rudiger Breiteneker</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/14/66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>Oct 18/66</b>	
23C. NAME of CEMETERY or CREMATORY <b>Bald. Natl Cem.</b>		23D. LOCATION (City, town, or county) (State) <b>5100 Patrick Cr.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
24C. FUNERAL DIRECTOR <b>Milton E. Ellickson</b>		ADDRESS <b>1129 N. Conquist St</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10422		CERTIFICATE OF DEATH		Registered No. 66 10422	
1. NAME OF DECEASED (Type or Print) <i>Middleton Carolyn</i>				2. DATE AND HOUR OF DEATH <i>Oct. 16 1966 1:10 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hospital</i> <i>43</i>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore City</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, MD 2506</i> D. STREET ADDRESS (If rural, give location) <i>1712 Brady Ave Balto 26, MD</i>					
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>3-28-36</i>		9. AGE (In years last birthday) <i>31</i>		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Williams</i>			14. MOTHER'S MAIDEN NAME <i>Edna Dorsey</i>			17. INFORMANT <i>Sylvester Middleton</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <i>1712 Brady Ave.</i>			
18. <i>416X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Rheumatic Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>approx. 2 years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <i>10-14</i> 19 <i>66</i> to <i>10-16</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>10-16</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.									
23A. SIGNATURE <i>William F. Smith M.D.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/16/66</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<i>Burial</i>		<i>Oct. 19/66</i>		<i>BALTO. NAT. CEM.</i>		<i>5501 Fried'K Ave</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<i>OCT 17 1966</i>		<i>Robert E. Jackson</i>		<i>William E. Elickson</i>		<i>1129 N. CAROLINE</i>			

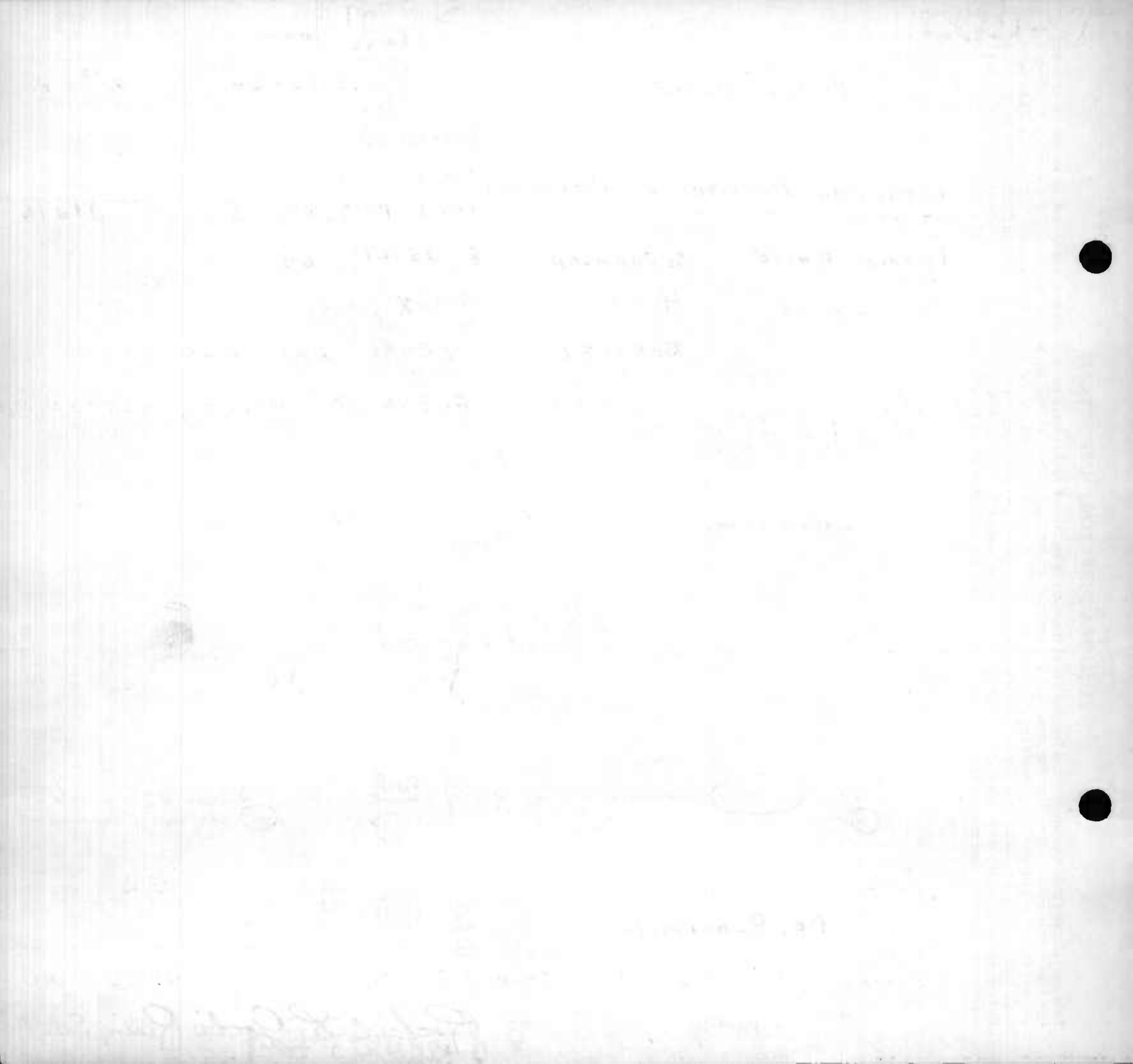




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

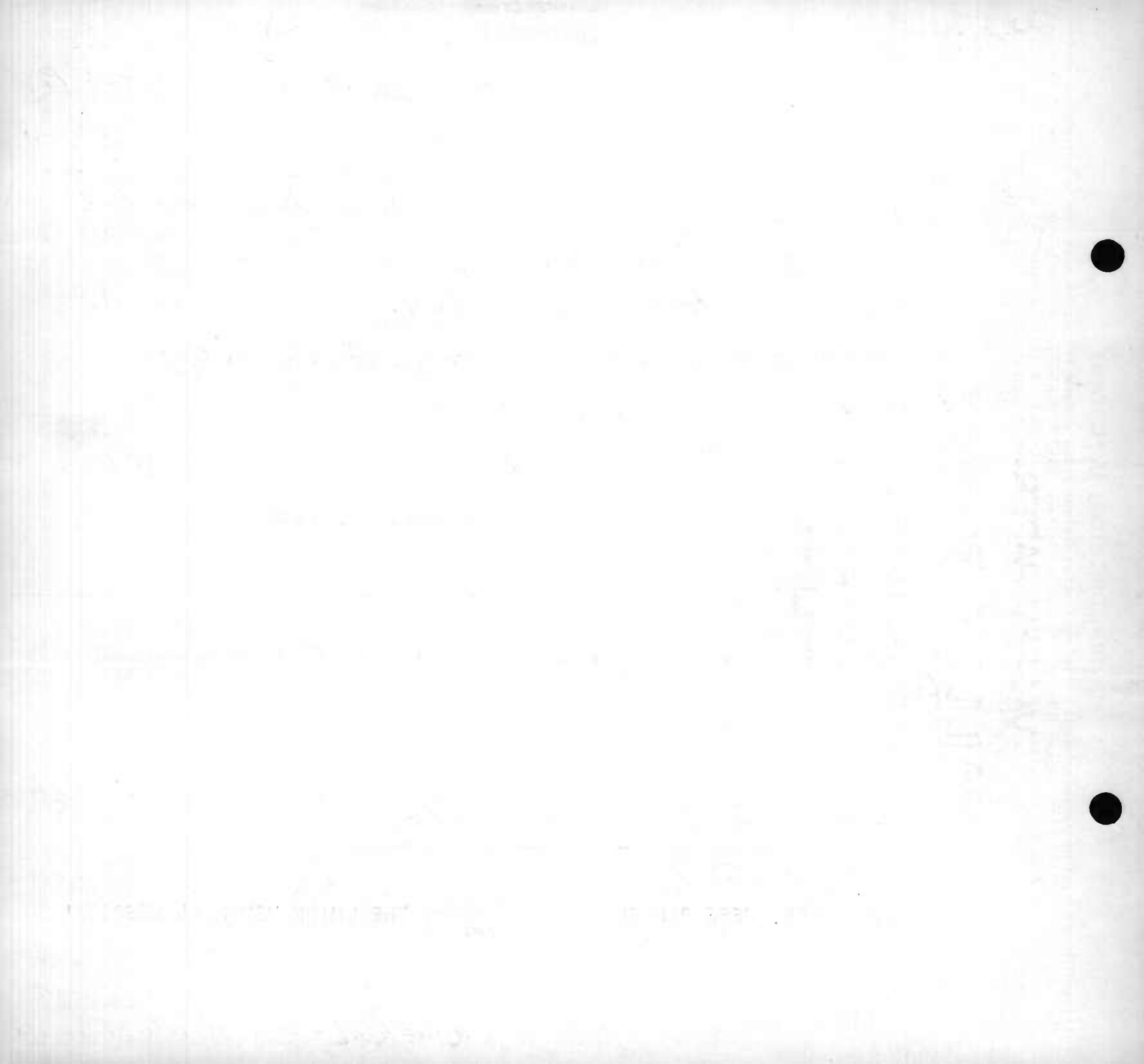
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 10423	
BIRTH NO. 66 10423		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PEARL MAY DOYLE</b>		2. DATE AND HOUR OF DEATH <b>10-12-66 2<sup>10</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		CITY OR TOWN (If outside city limits, write RURAL and give township)		STATE		COUNTY	
<b>LUTHERAN HOSPITAL OF MARYLAND</b>		<b>BALTIMORE</b>		<b>MARYLAND</b>			
<b>46</b>		<b>1501 DUKELAND STREET</b>		<b>21216</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SEPARATED</b>	8. DATE OF BIRTH <b>8-25-01</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>GALAX, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BARTLET</b>				14. MOTHER'S MAIDEN NAME <b>PEARL MAY BARTLET</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>GLENN R DOYLE</b>		ADDRESS <b>ELKTON, MD</b>	
18. <b>420.1 + 1260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO		<b>Arteriosclerotic Cardiovascular Disease</b>	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>1) Diabetes mellitus</b> <b>2) Urinary Tract Infection</b> <b>3) Fracture of Hip</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>9/26/1966</b> to <b>October 12, 1966</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>October 12, 1966</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.							
23A. SIGNATURE <b>Robert C. Blackmon, M.D.</b>				23B. DATE SIGNED <b>10/13/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. BLACKMON</b>				23D. ADDRESS			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/15/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>UNION CHURCH CEMETARY</b>		24D. LOCATION (City, town, or county) (State) <b>ELKTON, CECIL MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Richard L. Goodie</b>		ADDRESS <b>Rising Sun, Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 10424					CERTIFICATE OF DEATH			Registered No. 66 10424						
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Teske, Lawrence William					2. DATE AND HOUR OF DEATH 10-14-66 5:05 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSP					(If not in hospital or institution, give street address or location)					A. STATE MARYLAND B. COUNTY Balto. Co.				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					MIDDLE RIVER					53-00				
D. STREET ADDRESS (If rural, give location)					54 BEECH DRIVE APT B-2									
5. SEX MALE		6. RACE CAU		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE WIDOWED		8. DATE OF BIRTH 7-15-10		9. AGE (In years last birthday) 56		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN					10B. KIND OF BUSINESS OR INDUSTRY MARTIN CO.					11. BIRTHPLACE (State or foreign country) PENN.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME UNKNOWN G A Teske					14. MOTHER'S MAIDEN NAME UNKNOWN Anna Kopp				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN					16. SOCIAL SECURITY NO. 6257 NIECE					17. INFORMANT ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) HEPATIC Coma					INTERVAL BETWEEN ONSET AND DEATH 29 DAYS				
ANTECEDENT CAUSES					(B) CIRRHOSIS LIVER									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
NONE					NONE					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) NONE					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> No					21F. HOW DID INJURY OCCUR? NONE				
22. I certify that (I) (this hospital) attended the deceased from 10-3-1966 to 10-14-1966, that (I) (we) last saw the deceased alive on 10-14-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Jeff Parker					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 10-14-66				
23C. PHYSICIAN'S NAME (Type) DR. JEFF PARKER					23D. ADDRESS THE UNION MEMORIAL HOSP									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 10/18/66					24C. NAME of CEMETERY or CREMATORY Bush Creek K.				
24D. LOCATION (City, town, or county) Hempfield					24E. (State) Penna									
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1966					25B. NAME OF REGISTRAR Robert E. Farkner					25C. FUNERAL DIRECTOR ADDRESS TO F. F. Kline & Sons Reisters Town Md				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

66 10425

BIRTH NO.

66 10425

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

William Hamilton Whealton, Jr.

2. DATE AND HOUR OF DEATH

Oct. 11, 1966

10:55 P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

US Public Health Service Hospital  
Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Crisfield

D. STREET ADDRESS (If rural, give location)

Rt. 1 Box 371

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

9/18/13

9. AGE (In years  
last birthday)

53

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Coast Guard

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm. H. Whealton, Sr.

14. MOTHER'S MAIDEN NAME

Daisey Wise Brittingham

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1934-1961

16. SOCIAL  
SECURITY NO.

215-38-9170

17. INFORMANT

Records- US PHS Hospital, Balto, Md.

ADDRESS

18.

420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

14 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Chronic bronchitis

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept. 28 19 66 to Oct. 11 19 66,  
that (I) (we) lost saw the deceased alive on Oct. 11 19 66 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Vilis E. Kilpe, Surgeon

M.D.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

10/12/66

23C. PHYSICIAN'S  
NAME (Type)

Vilis E. Kilpe

M.D.

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/15/66

24C. NAME of CEMETERY or CREMATORY

Downing Cemetery

24D. LOCATION

Oak Hall, Virginia

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 17 1966

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

Salter Funeral Home, Chincoteague, Virginia

ADDRESS

I

00072

1  
P-652

66 10426

BALTIMORE CITY HEALTH DEPARTMENT

66 10426

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

FILE CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RALPH

PARENT

2. DATE AND HOUR PRONOUNCED DEAD

October 15, 1966

11:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3711 Brooklyn Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

June 15 1907

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Orlando Parent

14. MOTHER'S MAIDEN NAME

Margaret Crane

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW2

16. SOCIAL  
SECURITY NO.

215 16 6277

17. INFORMANT

Etta Becker 3711 Brooklyn Ave. Baltimore

ADDRESS

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) Congestive Heart Failure  
DUE TO

Arteriosclerotic Cardiovascular Disease

(B) DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Pulmonary Tuberculosis (by history)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/15/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/19/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 17 1966

24B. NAME OF REGISTRAR

Rudiger E. Breitenacker

24C. FUNERAL DIRECTOR

McCully F.H. 237 Patapasco Ave

ADDRESS



Report of the Director of the Bureau of Plant Industry

for the year ending June 30, 1911

Presented to the Senate and House of Representatives

at their respective sessions

January 15, 1912

Washington, D. C.

Printed by the Government Printing Office

under authority of Act of March 3, 1879

and Act of October 3, 1917

and Act of March 3, 1909

and Act of March 3, 1907

and Act of March 3, 1905

and Act of March 3, 1903

and Act of March 3, 1901

and Act of March 3, 1899

and Act of March 3, 1897

and Act of March 3, 1895

and Act of March 3, 1893

and Act of March 3, 1891

and Act of March 3, 1889

and Act of March 3, 1887

and Act of March 3, 1885

and Act of March 3, 1883



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HANS

STROEHLA

2. DATE AND HOUR PRONOUNCED DEAD

October 13, 1966

1:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6602 Rannock Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

10-25-1898

9. AGE (In years  
last birthday)

XX 67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

BAKER

10B. KIND OF BUSINESS OR INDUSTRY

VILLAGE BAKERY

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

FREDERICK STROEHLA

14. MOTHER'S MAIDEN NAME

MARGARET SICHERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

219-01-2662

17. INFORMANT

ADDRESS

MRS. CATHERINE FRANK, 6602 RANNOCH DRIVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive Pulmonary Embolism  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Blunt force injuries of head  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Thistle and River Roads

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 5 '66 between  
3:15 A m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently was beaten up

22.

I certify that I held on and 4:30 A Inspection Autopsy and that on this basis, death in my opinion  
resulted from: Natural causes Accident Suicide Homicide Undetermined mannerACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED

10/14/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-17-66

23C. NAME of CEMETERY or CREMATORY

LOUDON PARK CEMETERY

23D. LOCATION

(City, town, or county)

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

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10-10-68

BIRTH NO.

66 10428

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 10428

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOHN

AULT

2. DATE AND HOUR PRONOUNCED DEAD

October 10, 1966

10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 422 S. Dallas Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

422 S. Dallas Street 3-01

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

UNKNOWN

8. DATE OF BIRTH

UNKNOWN

9. AGE (In years  
last birthday)

about--73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

UNKNOWN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

UNKNOWN

12. CITIZEN OF  
WHAT COUNTRY?  
UNKNOWN

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL  
SECURITY NO.

377-20-4419A

17. INFORMANT

ADDRESS

REV. WILLIAM C. BOWLING, 1513 EASTERN AVENUE

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)  
BURIAL

23B. DATE

10-14-66

23C. NAME of CEMETERY or CREMATORY

LOUDON PARK CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND 21229

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 17 1966

Robert E. Jackson

HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229

VALLEY FORCE

## CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DARR, RAYMOND LEROY

2. DATE AND HOUR OF DEATH

10/16/66

3 30

P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)31 BALTIMORE CITY HOSP.  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE 21222

D. STREET ADDRESS (If rural, give location)

1250 Delbert Ave #21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-1-09

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Corp

11. BIRTHPLACE (State or foreign country)

Emeryville, West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

William Darr

14. MOTHER'S MAIDEN NAME

(Unk) Emma

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unk

1/8/'30-2/11/'33

16. SOCIAL  
SECURITY NO.

217-05-1123

17. INFORMANT

Baltimore City Hospital  
4940 Eastern Avenue  
Baltimore, Maryland #21224

18.

420.1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Myocardial infarction

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

36 hrs

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (This hospital) attended the deceased from 10/15 19 66 to 10/16 19 66,  
that (I) (we) last saw the deceased alive on 10/16 19 66 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Allen Ginsberg

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/16/66

23C. PHYSICIAN'S  
NAME (Type)

ALLEN GINSBERG

M.D.

23D. ADDRESS

4940 Eastern Avenue Balt., Md. #21224  
Balt. City Hospital24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/20/66 Baltimore National

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

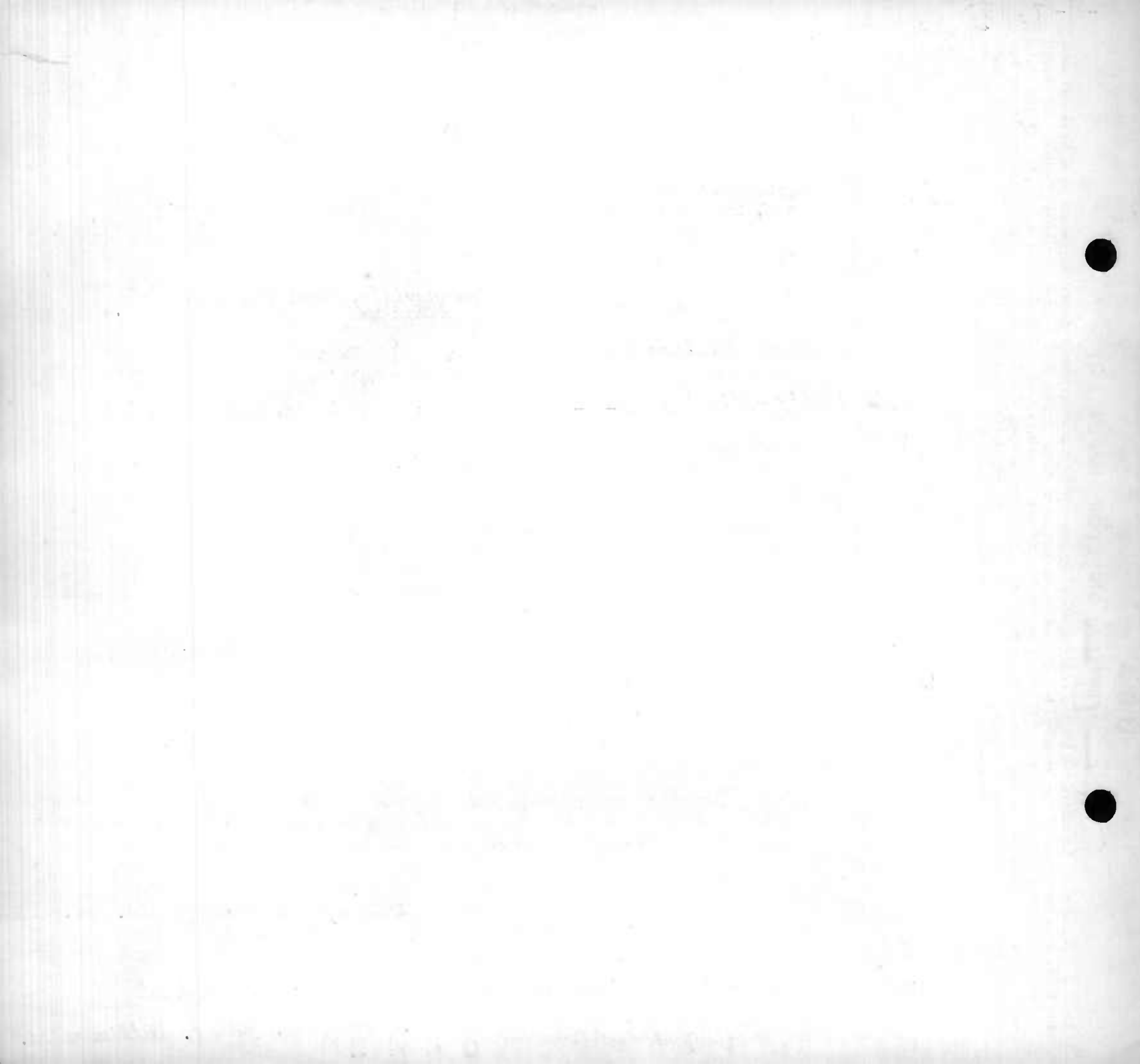
OCT 17 1966

John A. Moran, Inc.

3000 E. Baltimore St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

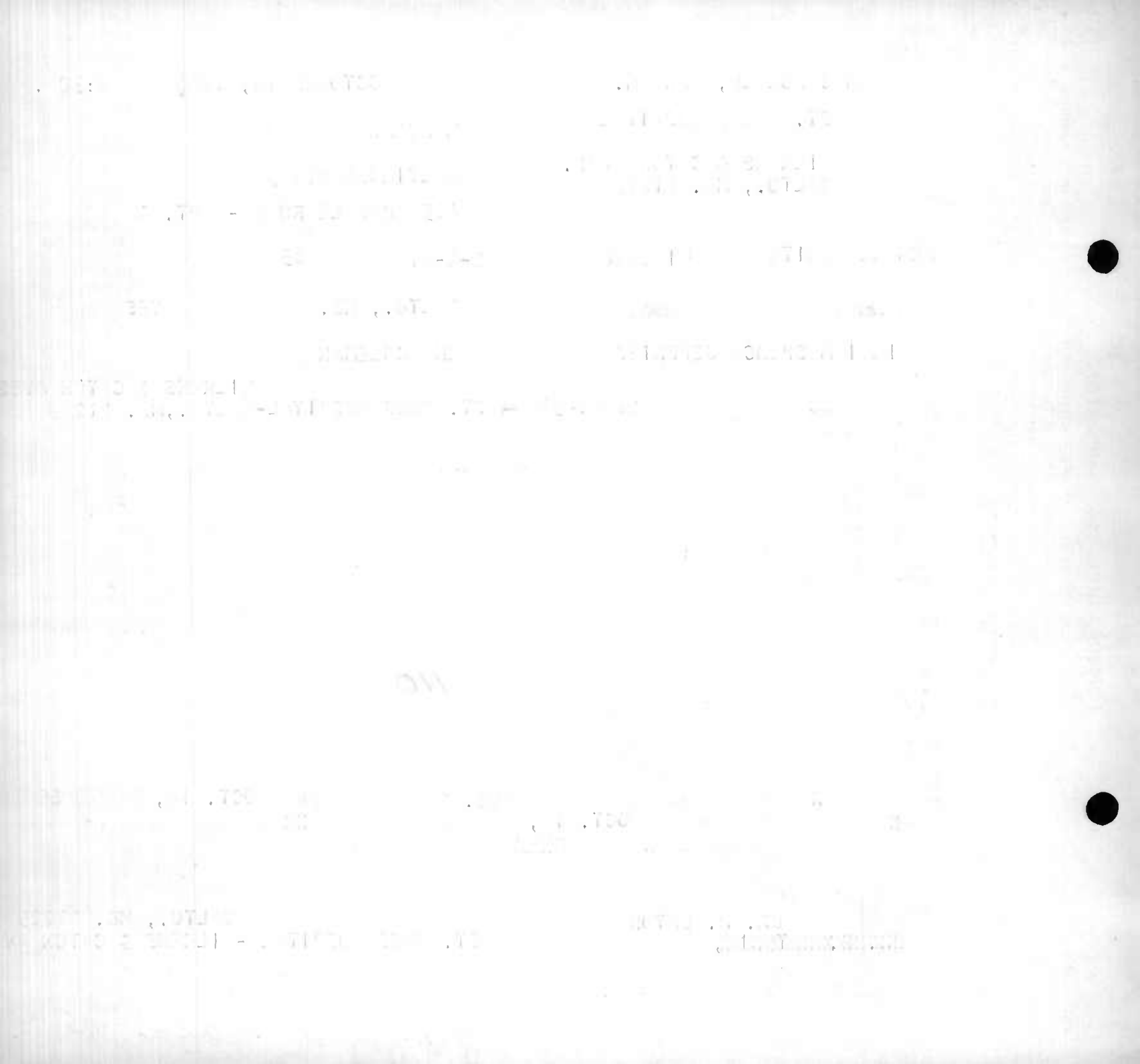




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
66 10430					CERTIFICATE OF DEATH					Registered No. 66 10430														
BIRTH NO. 66 10430										M.E. CASE NO.														
1. NAME OF DECEASED (Type or Print) <b>MAC DONALD, ANNA M.</b>										2. DATE AND HOUR OF DEATH <b>OCTOBER 14, 1966 6:30A.M.</b>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ST. AGNES HOSPITAL</b> (If not in hospital or institution, give street address or location) <b>WILKENS &amp; CATON AVES. BALTO., MD. 21229</b>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21229</b> D. STREET ADDRESS (If rural, give location) <b>413 EDSDALE ROAD - APT. B</b>														
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>2-4-81</b>		9. AGE (In years last birthday) <b>85</b>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>					11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>					12. CITIZEN OF WHAT COUNTRY? <b>YES</b>									
13. FATHER'S NAME <b>WILLIAM SPENSE JEFFRIES</b>										14. MOTHER'S MAIDEN NAME <b>ANNA COLEMAN</b>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>21201-3546A</b>					17. INFORMANT <b>WILKENS &amp; CATON AVES ST. AGNES HOSPITAL - BALTO., MD. 21229</b>														
18. <b>450.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Post- amputation, Diabetes Insipidus</b>										CAUSE OF DEATH (A) <b>Uremia</b> DUE TO					INTERVAL BETWEEN ONSET AND DEATH									
										(B) <b>Chronic Pyelonephritis</b> DUE TO														
										(C) <b>Generalized Arteriosclerosis</b> DUE TO														
19A. DATE OF OPERATION <b>0</b>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>NO</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that <b>X</b> (this hospital) attended the deceased from <b>AUG. 26, 1966</b> to <b>OCT. 14, 1966</b> , that <b>X</b> (we) lost saw the deceased alive on <b>OCT. 14, 1966</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) <b>XXXX</b> view the body after death.																								
23A. SIGNATURE <b>Romualdo J. Dator</b>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>Oct. 14, 1966</b>									
23C. PHYSICIAN'S NAME (Type) <b>DR. R. DATOR</b>										23D. ADDRESS <b>BALTO., MD. 21229 ST. AGNES HOSPITAL - WILKENS &amp; CATON AV</b>														
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>10/17/66</b>					24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem. Balto., Md.</b>					24D. LOCATION (City, town, or county) (State)									
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>					25C. FUNERAL DIRECTOR <b>Wm. J. Fisher &amp; Sons</b>					ADDRESS <b>Balto. Md.</b>									





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10431</b>	
BIRTH NO. <b>66 10431</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PIERZCHALSKI, JOHN</b>		2. DATE AND HOUR OF DEATH <b>10-12-66 8:10 PM.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles General Hosp</b>		A. STATE <b>Md.</b> B. COUNTY <b>24-01</b>			
CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 30</b>		D. STREET ADDRESS (If rural, give location) <b>1359 Andrea St.</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5-25-84</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>		13. FATHER'S NAME <b>2/4 Known</b>		14. MOTHER'S MAIDEN NAME <b>2/4 Known</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-3274</b>		17. INFORMANT ADDRESS <b>John Pierzchalski 1606 E. Clement St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>156.1 I</b>		CAUSE OF DEATH (A) <b>Carcinoma of Liver</b> DUE TO (B) <b>Unknown Primary Site</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>8 wks ±</b>	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>10-3 1966</b> to <b>10-12 1966</b> , that (X) (we) last saw the deceased alive on <b>10-12 1966</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. J. Dureza</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-12-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. J. Dureza</b>		23D. ADDRESS M.D. <b>C/O North Charles General Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/17/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>			
25B. NAME OF REGISTRAR <b>John E. Ford</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Chas. E. Stevens Funeral Home, Inc. 4511 E. Fort Ave</b>			

2-7-85

54

51-01

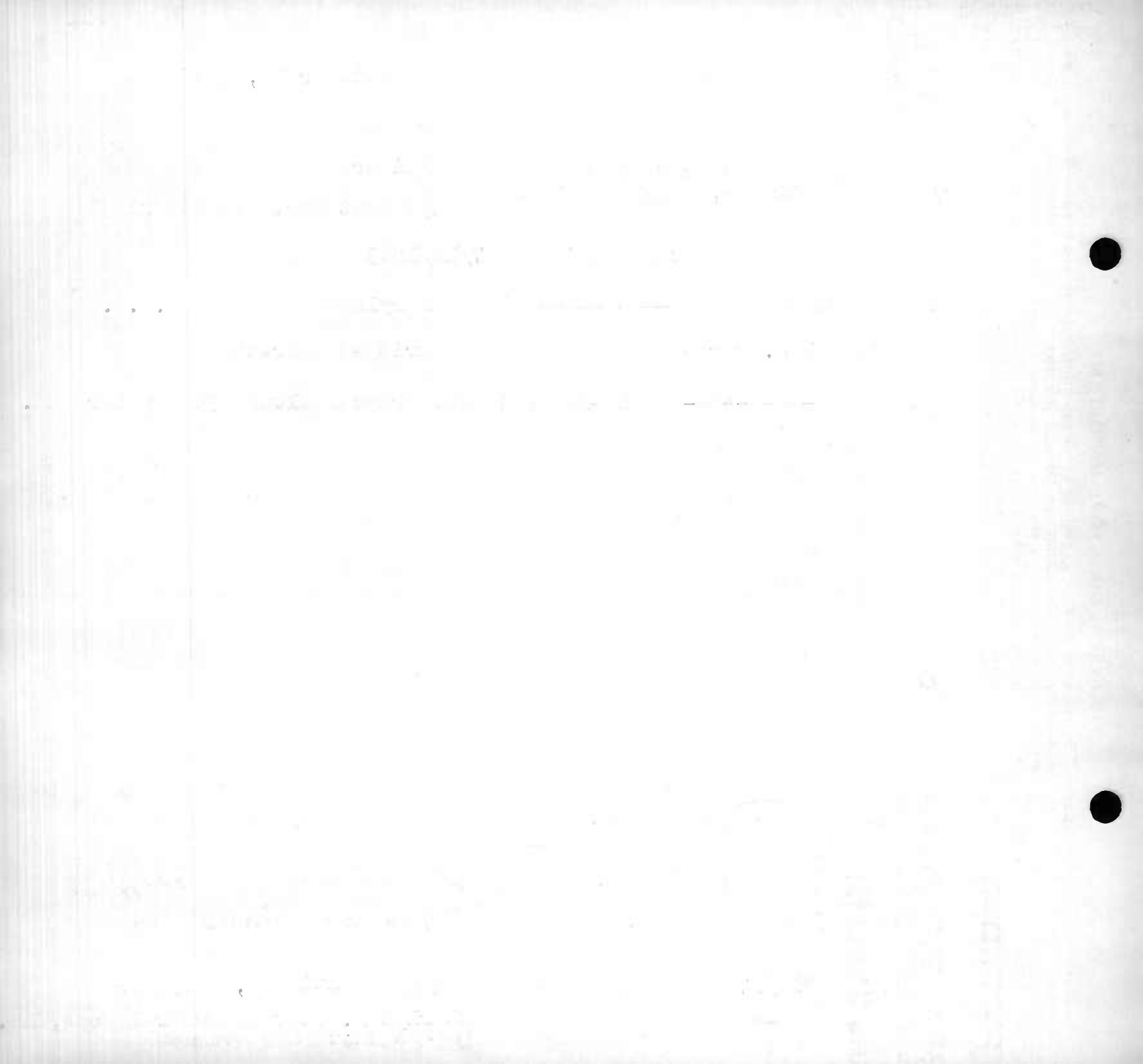
E-01  
50

R. J. Davies

NO-15-01

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

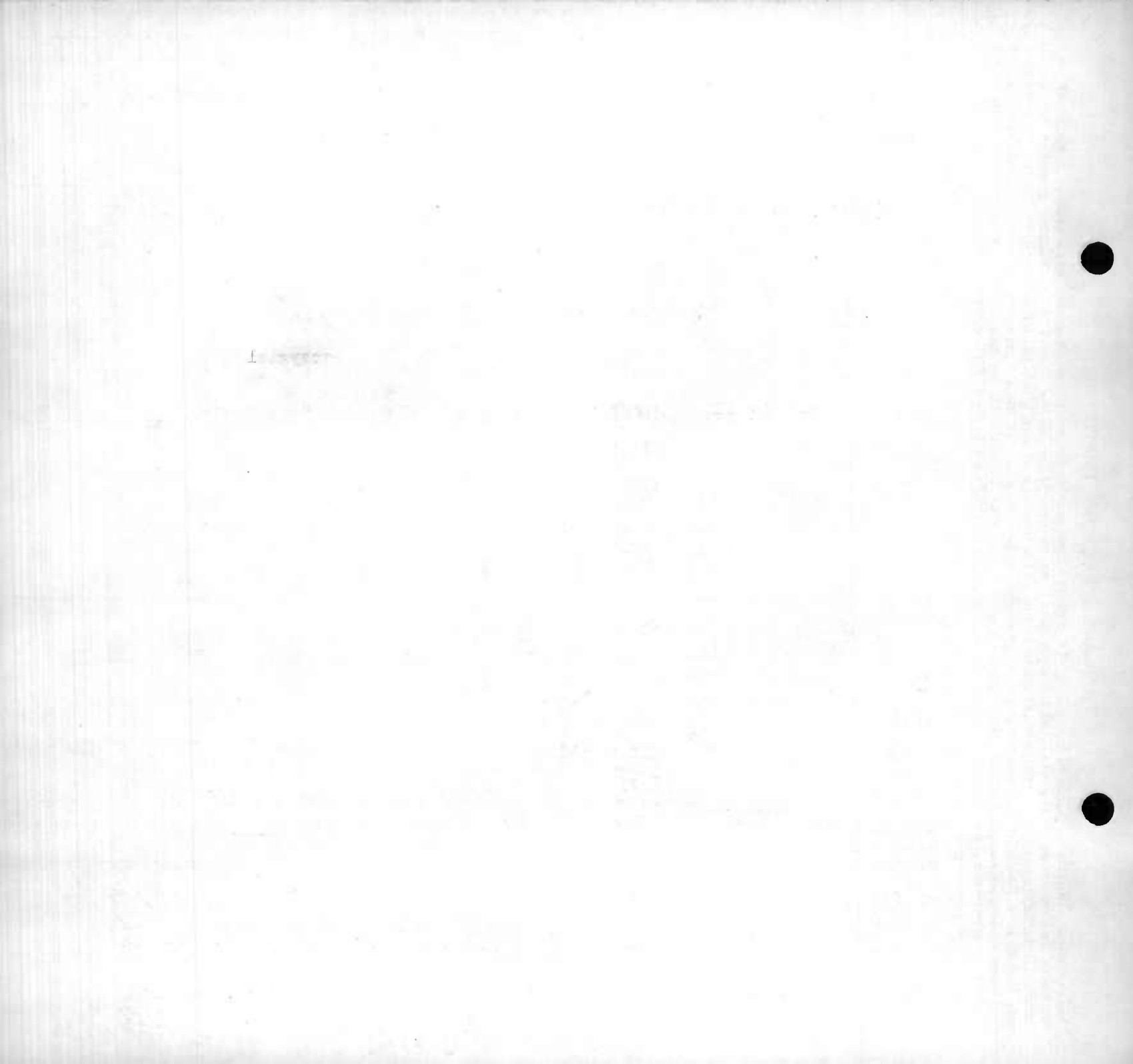
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10432</u>	
BIRTH NO. <u>66 10432</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>66 10432</u>		1. NAME OF DECEASED (Type or Print) <u>John Leo Burke</u>		2. DATE AND HOUR OF DEATH <u>October 14, 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1336 East Fort Avenue</u> <u>Baltimore, Maryland 21230</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1336 East Fort Avenue 21230</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>7/16/1883</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael J. Burke</u>			
14. MOTHER'S MAIDEN NAME <u>Bridget Barrett</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-10-6984</u>		17. INFORMANT ADDRESS <u>Mrs. Frances Slough 35 Aquahart Rd.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic myocarditis</u> <u>insufficiency</u> <u>general and cerebral arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>2 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 19 63</u> to <u>Oct. 14 19 66</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26 19 66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis E. Wice</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/14/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>LOUIS E. WICE</u>		23D. ADDRESS <u>920 ST. PAUL ST.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/17/66</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1966</u>			
25B. NAME OF REGISTRAR <u>Paul E. Fink</u>		25C. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u>			
25D. ADDRESS <u>1201 East FORT Avenue</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

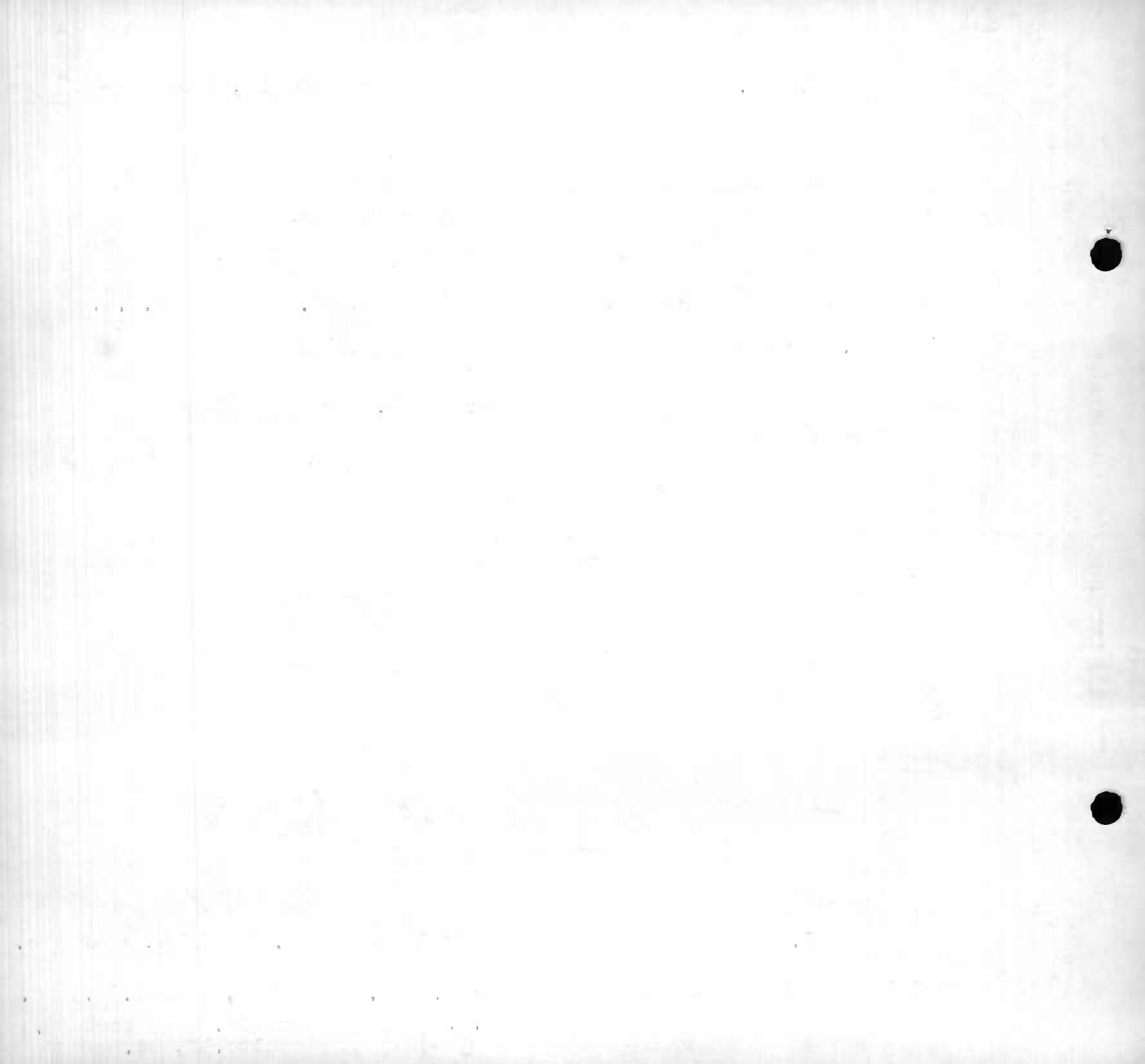
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10433</span>	
BIRTH NO. <span style="float: right;">66 10433</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>JACEK, STANLEY</i>		2. DATE AND HOUR OF DEATH <i>October 14, 1966 9:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Balts. Co.</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>721 Templecliff Rd</i>	
6. SEX <i>M</i>	7. RACE <i>white</i>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	9. DATE OF BIRTH <i>11/28/11</i>	10. AGE (in years last birthday) <i>54</i>	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Silbers Bakery</i>		11. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Joseph Jacek</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Szczygiel</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes World War II</i>		16. SOCIAL SECURITY NO. <i>024-07-6557</i>		17. INFORMANT <i>Medical Records</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of prostate</i>		CAUSE OF DEATH (A) DUE TO <i>metastases to bone, skin &amp; lymph nodes</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 16 1966</i> to <i>Oct 14 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct 14 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Garry N. Rosenbaum</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/14/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>GARRY N. ROSENBAUM</i>		23D. ADDRESS <i>Montebello State Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/18/1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Wm. J. Zimant</i>		25C. FUNERAL DIRECTOR <i>Balts. mtl. north Pa.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10434		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10434	
1. NAME OF DECEASED (Type or Print) Evelyn J. New			2. DATE AND HOUR OF DEATH October 14, 1966 2 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Edgewood Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 515 Hollen Road		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/26/1890	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank M. Gibbons			14. MOTHER'S MAIDEN NAME Sadie Phillips		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Archey C. New (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Atherosclerotic Cardiovascular Disease (B) DUE TO Pneumonia (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3-4 Yrs. One week.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1963 to Oct 1966, that (I) (we) last saw the deceased alive on Oct 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Emmett Queen			23B. DATE SIGNED 10/17/66		
23C. PHYSICIAN'S NAME (Type) J. Emmett Queen			23D. ADDRESS Medical Arts Bldg. or 115 W. Lake Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17/66		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Grds.	
24D. LOCATION Timonium, Balto. Co., Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 17 1966		24F. NAME OF REGISTRAR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	
24G. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					

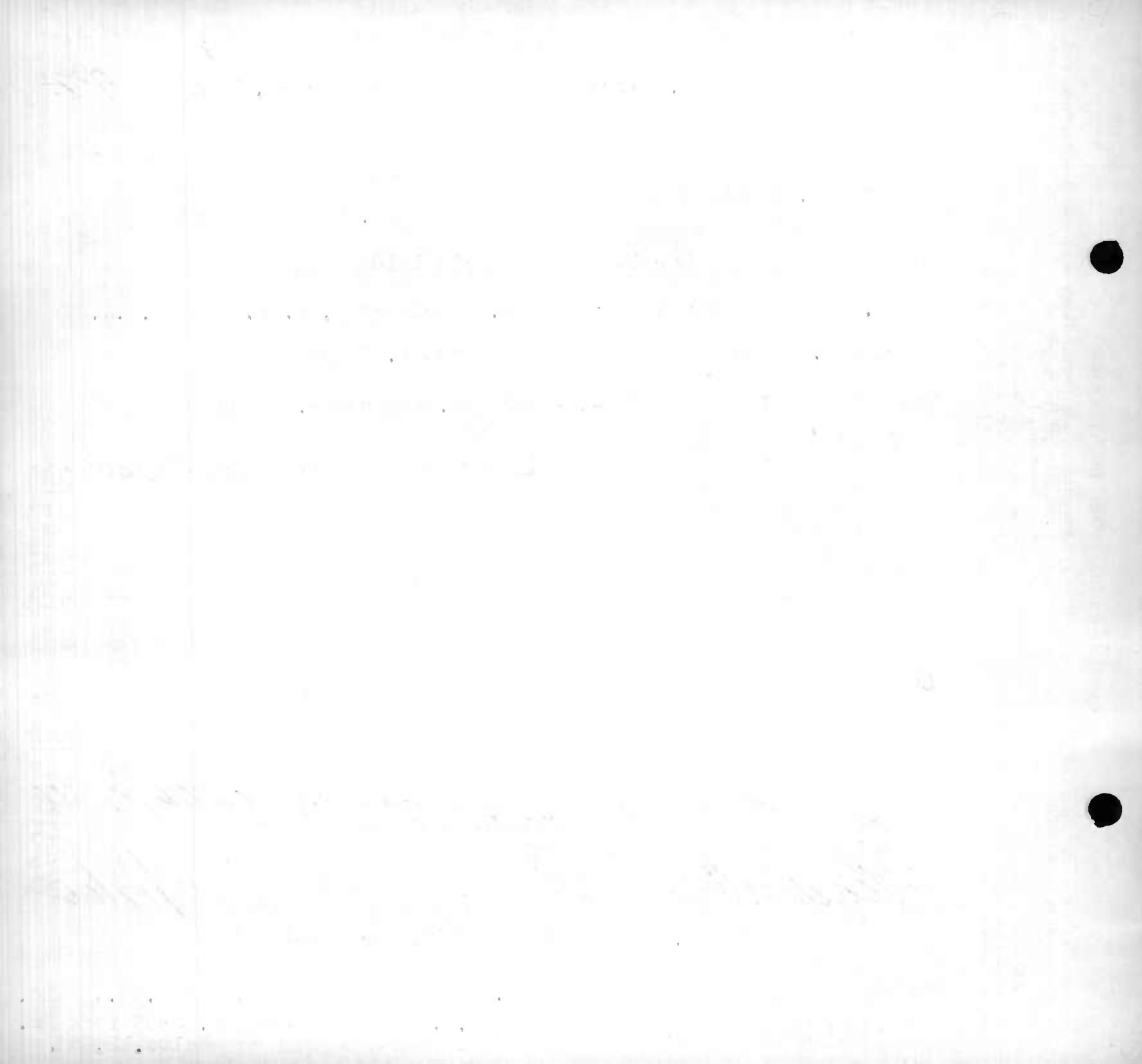




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10435	
BIRTH NO. 66 10435		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Charles J. Beers</b>		2. DATE AND HOUR OF DEATH <b>October 16, 1966 9:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1008 St. Dunstons Road</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>1008 St. Dunstons Road</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/12/1918</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clark Concrete Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Burlington, N. J.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles P. Beers</b>		14. MOTHER'S MAIDEN NAME <b>Grace L. James</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>219-05-5044</b>		17. INFORMANT <b>Mrs. Margaret H. Beers</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.11</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion Sudden</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 48</b> to <b>October 17 1966</b> , that (I) <b>did</b> last saw the deceased alive on <b>October 13 1966</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>did</b> (did not) view the body after death.					
23A. SIGNATURE <b>Charles F. O'Donnell</b> M.D.				23B. DATE SIGNED <b>10/17/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>				23D. ADDRESS <b>7501 York Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/18/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Mem. Park</b>	
24D. LOCATION <b>Parkville, Balto. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25D. ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

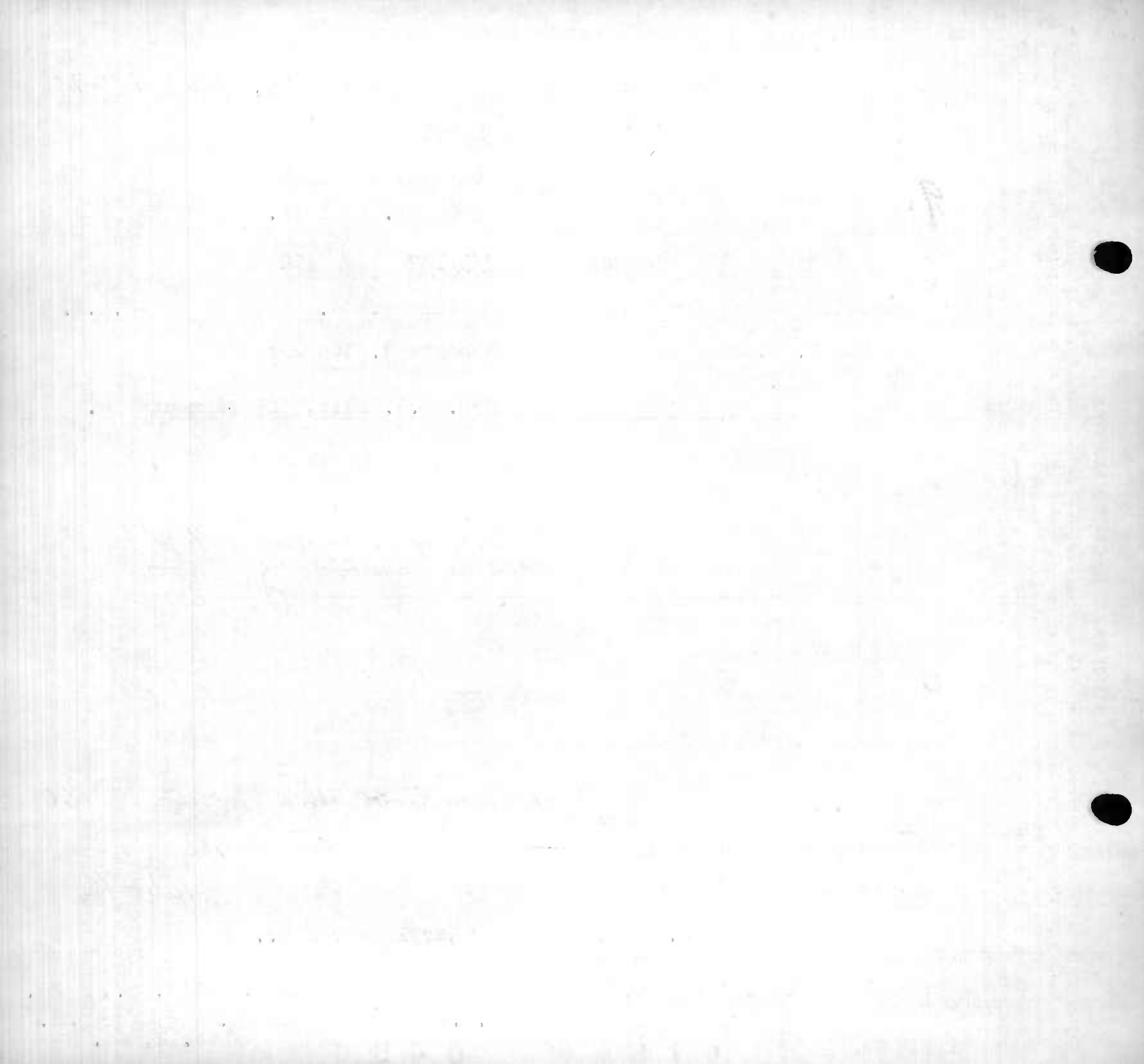
66 10436		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10436	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH	
M.E. CASE NO. <i>Libbet, William Thomas</i>				10-15-66 505 P.M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
<i>William Thomas Sibaet</i>		<b>CERTIFICATE AMENDED</b>		A. STATE B. COUNTY	
(If not in hospital or institution, give street address or location)		FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
10-21-66		91 <i>Keswick Home</i>		D. STREET ADDRESS (If rural, give location)	
				BALTIMORE 13-07	
				700 W. 40 <sup>th</sup> ST.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M.	W.	Married	4-27-78	88	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Accountant - Period Acctg.</i>		<i>Period Acctg.</i>		York Pa.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>Alexander Libbet</i>		<i>Arvilla Herman</i>		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216-127637A		Claribel C. Vickers R. H.	
18. <i>420.0 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>Atherosclerotic Heart Disease</i>		1 yr.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) <i>Severe Emphysema</i>			
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/21 1966 to 10-15 <sup>th</sup> 1966, that (I) (we) last saw the deceased alive on 10-15 <sup>th</sup> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>E. Hunter Wilson, Jr.</i>				10-17-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E. Hunter Wilson, Jr.		Keswick - 700 West Fortieth Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/18/1966		Prospect Hill	
24D. LOCATION		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
York Pa.		H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 17 1966		P. G. E. Johnson		H.W. Jenkins & Sons Co.	

Letter from Dr. Aubrey D. Richardson  
Medical Director Resnick Home 10-24-66 M. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10437</u>	
BIRTH NO. <u>66 10437</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Jennie Dunn</u>		2. DATE AND HOUR OF DEATH <u>October 15, 1966</u>   <u>5.27 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Long Green Nursing Home</u>		A. STATE <u>Maryland</u> B. COUNTY _____			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21218</u>			
		D. STREET ADDRESS (If rural, give location) <u>3501 St. Paul St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7/3/1874</u>	9. AGE (In years lost birthday) <u>92</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Charles F. Fiske</u>		14. MOTHER'S MAIDEN NAME <u>Roberta R. Stewart</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Wm. A. Gault, 505 Yarmouth Rd.</u>	
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Central Vascular accident.</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Central &amp; General Art. Sclerosis</u>		(B) DUE TO <u>Art. Sclerosis - (Left C.V.A.) - 1 yr. ago.</u>			
		(C) <u>Chronic Emphysema</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>Oct 15 - 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct. 14</u> , 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>Oct 15 - 1966</u>					
23A. SIGNATURE <u>Bernard J. Cohen</u>				23B. DATE SIGNED <u>10/15/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bernard J. Cohen</u>				23D. ADDRESS <u>Marylander Apts.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/18/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>	
24D. LOCATION <u>Pikesville, Balto. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10438</b>	
BIRTH NO. <b>66 10438</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CLIFTON H. FOX</b>		2. DATE AND HOUR OF DEATH <b>10-15-66 11:35 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MonteBello State Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md. 21202</b>			
<b>91</b>		D. STREET ADDRESS (If rural, give location) <b>1301 St. PAUL ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>7/23/05</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. ticket seller</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Edw. H. Fox</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>917-01-4779</b>		14. MOTHER'S MAIDEN NAME <b>IDA M. HANCOCK</b>	
17. INFORMANT <b>ROBERT J. FOX</b>		ADDRESS <b>PR WY 224 E. UNIVERSITY</b>			
18. <b>334X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Prob Brain Stem Hemorrhage</b> DUE TO <b>or thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
ANTECEDENT CAUSES		(B) <b>Generalized + Cerebral Arteriosclerosis</b> DUE TO		<b>YEARS</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Anterior Spinal Artery insufficiency</b>		<b>Quadruparesis</b>	
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-28</b> 19 <b>65</b> to <b>10-15</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10-15</b> 19 <b>66</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hugh Boyd Watts</b>		M.D.	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>10-15-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hugh Boyd Watts</b>		M.D.	23D. ADDRESS <b>Montebello State Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>	24B. DATE <b>10/19/1966</b>	24C. NAME OF CEMETERY or CREMATORY <b>Fairview Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Roanoke, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1966</b>		25B. NAME OF REGISTRAR <b>W. E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>	

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A-120

66 10439

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 10439

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS

R.

AYRES

2. DATE AND HOUR PRONOUNCED DEAD

October 13, 1966

8:30 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

735 E. 22nd Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

735 E. 22nd Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Dec. 2, 1882

9. AGE (in years  
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labourer

10B. KIND OF BUSINESS OR INDUSTRY

Auto. Industry

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Ayers

14. MOTHER'S MAIDEN NAME

Cecilia Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

715-10-2997

17. INFORMANT

ADDRESS

Wm. Ayers, 735 E. 22nd St. Balto. Md.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
(If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
10/13/6623A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/17/66

23C. NAME of CEMETERY or CREMATORY

Pleasant Rest

23D. LOCATION

(City, town, or county)

(State)

Towson, Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 17 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. L. Chatman, 1701 N. E. Cullloch St

ADDRESS

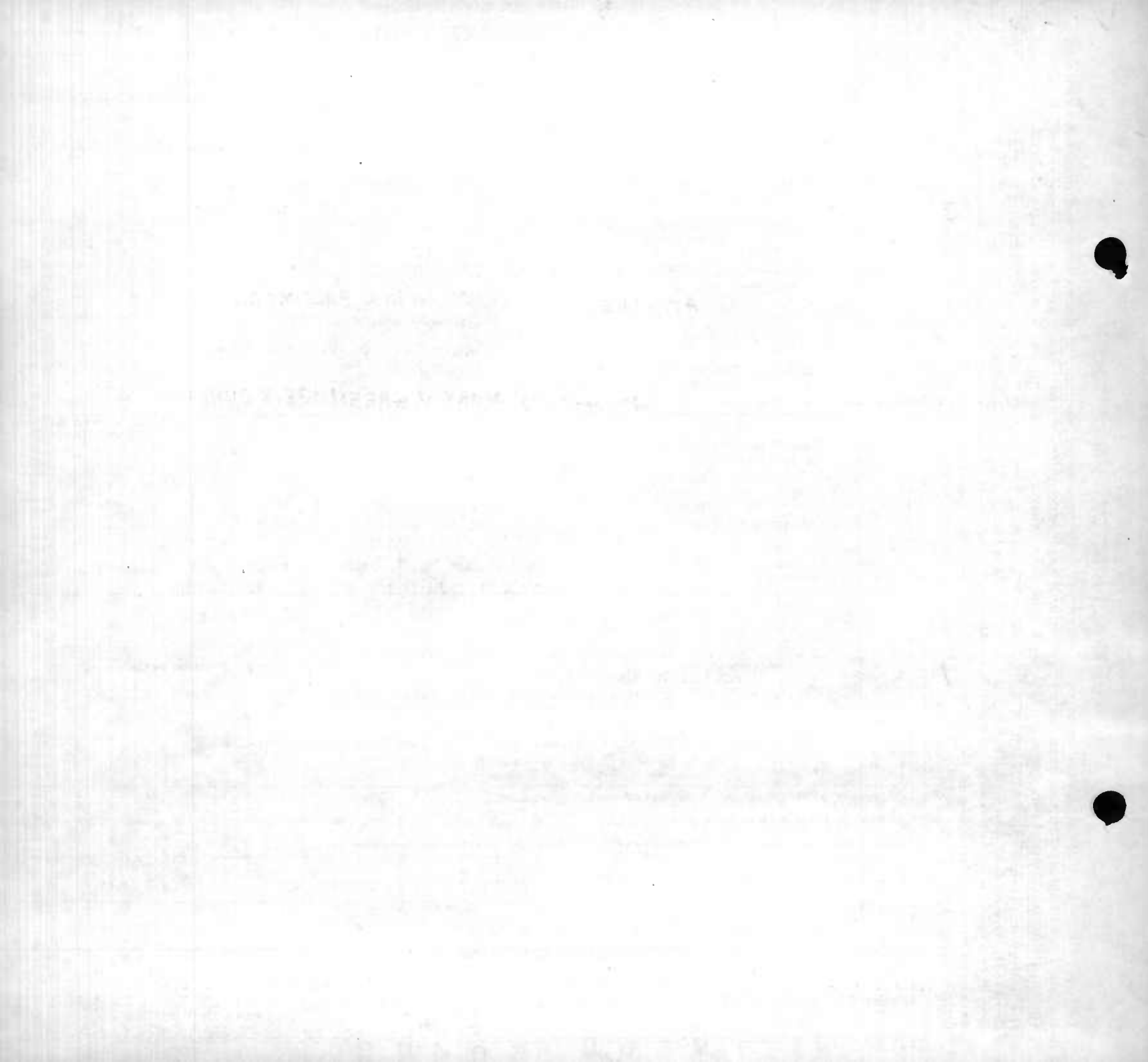
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death, was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

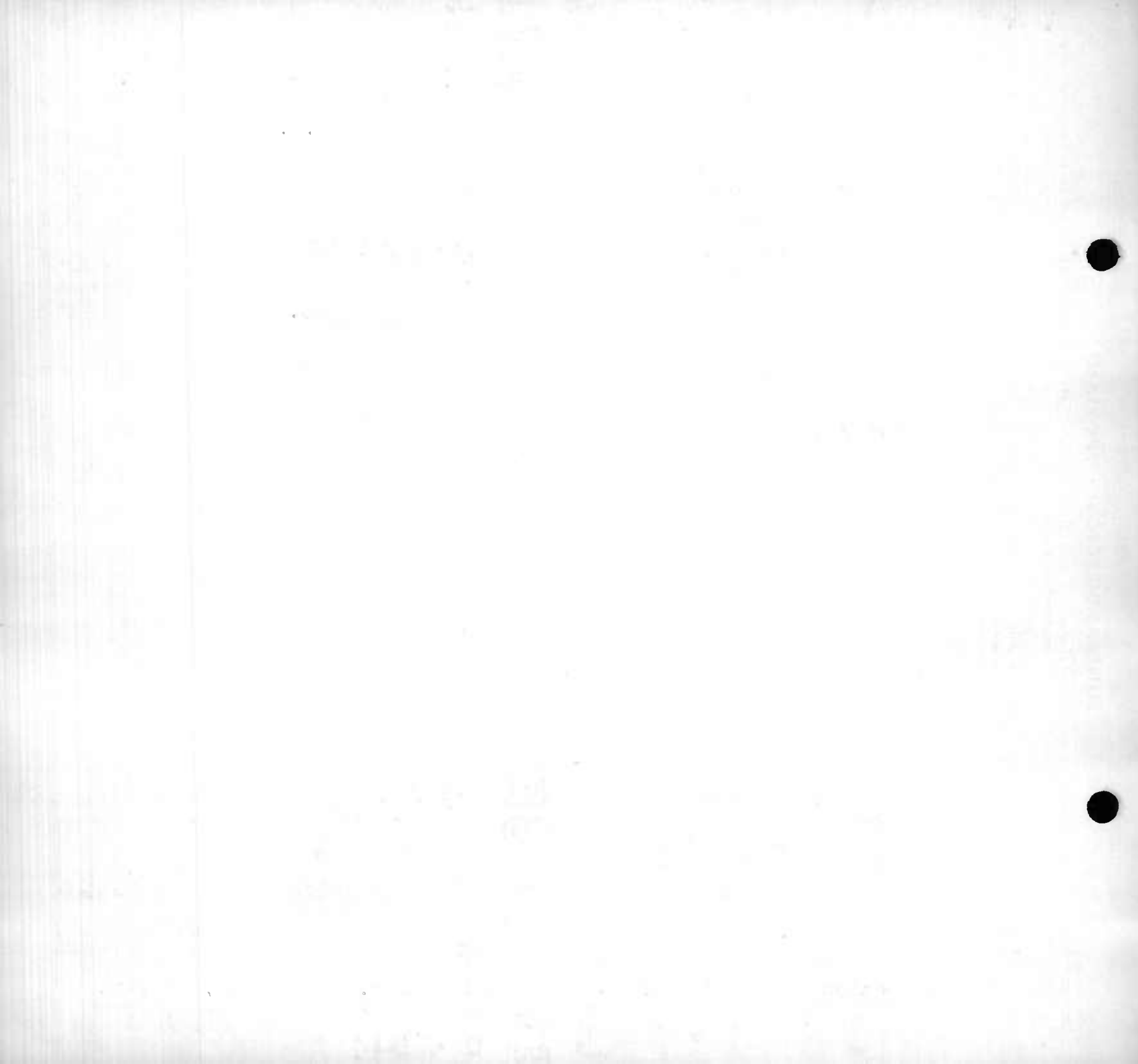
BIRTH NO. 66 10440		BALTIMORE CITY HEALTH DEPARTMENT		66 10440	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) Mamie P. Vogtmann			2. DATE AND HOUR OF DEATH 3:45 PM 10-13-66		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital			A. STATE md		
(If not in hospital or institution, give street address or location)			B. COUNTY		
37			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
5. SEX Female			D. STREET ADDRESS (If rural, give location) 3821 Fair Ave. # 21224.		
6. RACE Caucasian		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 8-14-93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10B. KIND OF BUSINESS OR INDUSTRY AT HOME.		9. AGE (In years lost birthday) 73	
13. FATHER'S NAME Augustus Patzwall		14. MOTHER'S MAIDEN NAME Kunigunda Waechter		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 216-14-3770		17. INFORMANT MARY V. GREEN; 3518 DUNHAVEN RD. BALTO, 22, MD.	
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO adenocarcinoma of uterus & (C) metastasis to rt. ureter + rectum & rupture of rectum + localized peritonitis unknown		
19A. DATE OF OPERATION 10-4-66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED rectal mass		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond E. Knowles, Jr.				23B. DATE SIGNED 10-13-66	
23C. PHYSICIAN'S NAME (Type) RAYMOND E. KNOWLES, JR.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-17-66		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Charles S. Giler	
24D. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. BALTO, Co., MD.		24E. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66-22249 66 10441		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10441 7	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED		10-13-66 9.15 P.M.	
(Type or Print)		BABY GIRL SIBLEY (of Nellie)			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  THE JOHNS HOPKINS HOSPITAL 33			A. STATE MARYLAND B. COUNTY A.A. 9.9.Co.		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) LINTHICUM 52-00		
D. STREET ADDRESS (If rural, give location) 515 HAWTHORNE ROAD					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED, DIVORCED, (specify) NEVER MARRIED	10/13/66	10/13/66	11 35
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
RALPH SIBLEY			NELLIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Hyaline Membrane Disease		
ANTECEDENT CAUSES			(B) Prematurity & maternal diabetes		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 10/13/66 9:40 AM to 10/13/66 9:15 AM 19 66, that (1) last saw the deceased alive on 10/13 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
H. SWICK			10/13/66		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
H. SWICK			THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation		10/14/66		The Johns Hopkins Hosp. Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 18 1966		J. E. Sibley		MORTUARY SERVICE - BCHD	



L-563 66-21140 10442

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 10442 4

BIRTH NO. 66-21140 10442		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Leonard, Baby Boy JOYCE		2. DATE AND HOUR OF DEATH 10-7-66 3:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 4940 Eastern Avenue Baltimore, Maryland 21224 31 Baltimore City Hospital				A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, with RURAL and give township) BALTIMORE 15-12			
D. STREET ADDRESS (If rural, give location) 2804 VIOLET AVENUE 21215							
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 10-6-66	9. AGE (In years last birthday) 3	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 38		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Immature Infant		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alvin Paul Leonard				14. MOTHER'S MAIDEN NAME JOYCE TODD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH-4940 EASTERN AVENUE 21224 Mother 4819 Madison Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 776X I (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Immature Infant DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 hrs 38 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-6-66 (1132 PM) to 10-7-66 (3:10 AM) and that (I) (we) last saw the deceased alive on 10-7-66 (3:10 AM) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James T. Stinnett M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 7, 1966	
23C. PHYSICIAN'S NAME (Type) JAMES T. STINNETT				23D. ADDRESS M.D. 4940 EASTERN AVENUE, BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 10-10-66		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			

OCT 18 1966

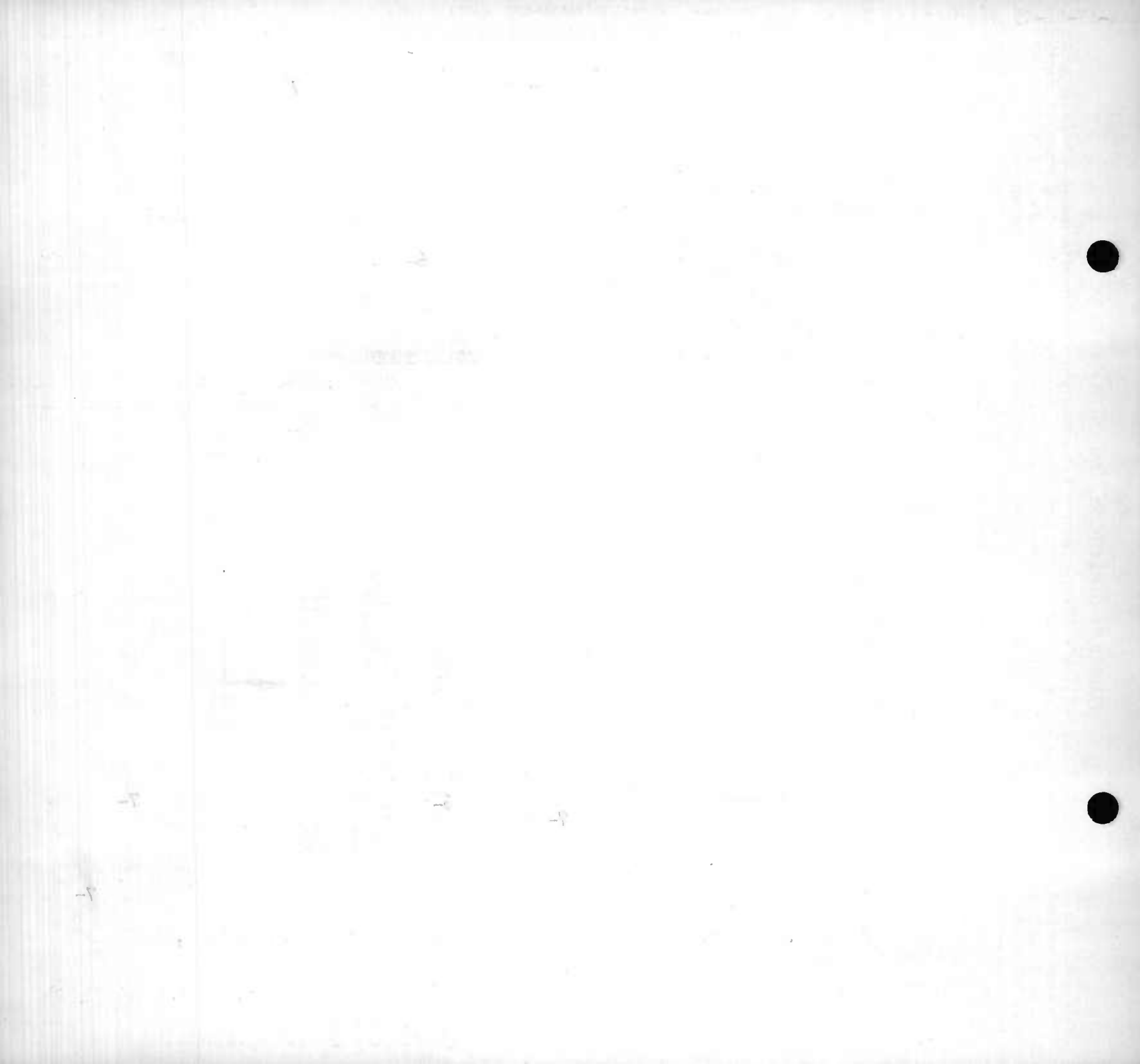
J. E. F. J. F. J. F.

0 4 3

MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

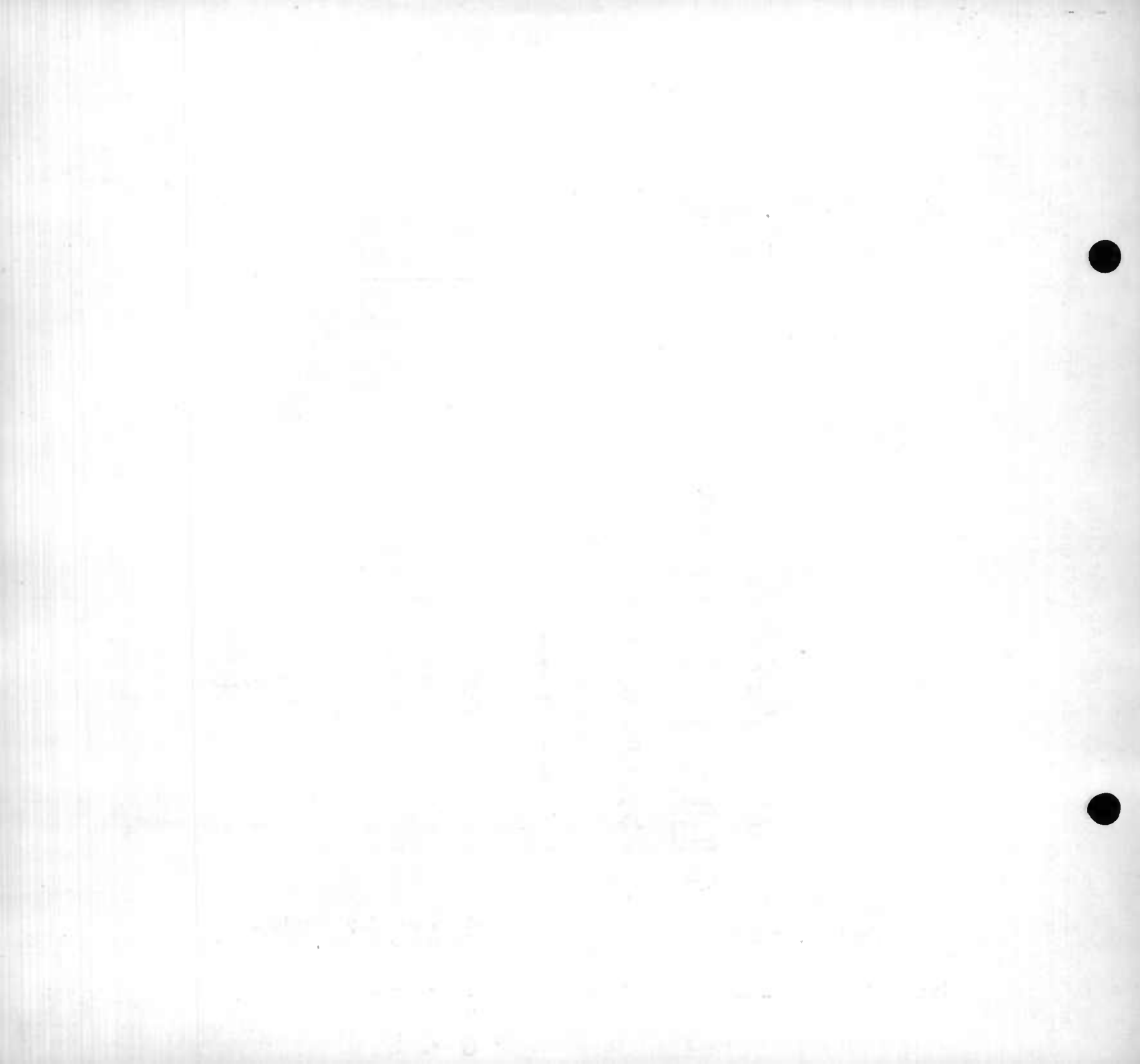




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-85-40 ED 1M-265				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10443 4	
BIRTH NO. 66-20769 66 10443				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Mc Cormick</b>				2. DATE AND HOUR OF DEATH <b>10-4-66 11:50 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITAL # 21224</b> <b>4940 Eastern Ave. Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balt. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1707 Evergreen Drive</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>10-4-66</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>2 20</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(INFANT)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Mc Fadden</b>				14. MOTHER'S MAIDEN NAME <b>Patricia Mc Cormick</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Patricia Mc Cormick 1707 Evergreen Drive</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>776X I</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Immature Infant</b> (B) (C)  INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs 20 min</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9:35 PM 10-4-1966</b> to <b>11:50 PM 10-4-1966</b> , that (I) (we) last saw the deceased alive on <b>10-4 (11:50 PM) 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James T. Stinnett, M.D.</b>				23B. DATE SIGNED <b>10-4-66</b>		23C. PHYSICIAN'S NAME (Type) <b>James T. Stinnett</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>10-5-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland # 21224</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>0 4 5</b>		ADDRESS	



D-520

66 10444

BALTIMORE CITY HEALTH DEPARTMENT

66 10444

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELINOR Slingsluff DOWNES

2. DATE AND HOUR PRONOUNCED DEAD

October 16, 1966 12:35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

135 W. Lanval Street  
(LANVALE)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

135 W. Lanval Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Divorced

8. DATE OF BIRTH

Aug. 18, 1899

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)  
Secty.,10B. KIND OF BUSINESS OR INDUSTRY  
Church

11. BIRTHPLACE (State or foreign country)

Prb.: Pikesville, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

HARRY LEE SLINGLUFF

14. MOTHER'S MAIDEN NAME

JANE YATES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)  
No16. SOCIAL  
SECURITY NO.  
214-01-6504

17. INFORMANT (Son)

ADDRESS

Wm. Wallace Downes, 6412 Pratt Av., City 12

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/16/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

Oct. 18, 1966

23C. NAME of CEMETERY or CREMATORY

Druid Ridge

23D. LOCATION

(City, town, or county)

(State)

Pikesville, Balto. Cl., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

STEWART &amp; MOWEN CO., 108 W. North Av., City

WALLER FOLIO

WALLER FOLIO

WALLER FOLIO

WALLER FOLIO

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10445		TYLER		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10445	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
GREGORY KIRKPATRICK				25/P 14 Oct 66 255/P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				MARYLAND		Cecil Co.	
5. SEX MALE				6. RACE WHITE			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD				8. DATE OF BIRTH 9-27-66		9. AGE (In years last birthday) 17	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE				NONE		ELKTON, MARYLAND	
13. FATHER'S NAME HERBERT HOBERT B. KIRKPATRICK				14. MOTHER'S MAIDEN NAME KAREN LEMON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT: Father ADDRESS Cecil Co. Hobert B. Kirkpatrick, P.O. Box 192, Elkton,	
NONE				NONE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Acidosis and Hyperkalemia DUE TO		24 hrs	
				(B) Transposition of the Great Vessels DUE TO		birth	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 13 Oct 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Congenital Heart Disease		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1 Oct 1966 to 14 Oct 1966, that (I) (we) last saw the deceased alive on 14 Oct 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William E. Mitchell Jr M.D.				23B. DATE SIGNED 14 Oct 66			
23C. PHYSICIAN'S NAME (Type) William E. Mitchell Jr M.D.				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/21/66		24C. NAME OF CEMETERY or CREMATORY Patton Cemetery		24D. LOCATION (City, town, or county) (State) Meadow Bridge, Greenbrier Co., W. Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO., 108 W. North Av., City			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10446		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10446	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Christopher Mary.		2. DATE AND HOUR OF DEATH Oct. 16 1966 6:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin Square Hospital		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1113 W. Lombard St.			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 8/22/04	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOOD CANNER		10B. KIND OF BUSINESS OR INDUSTRY WRIGHTSON CO.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Noah Whitby		14. MOTHER'S MAIDEN NAME Margaret Morris	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-4054		17. INFORMANT Hospital chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 491X I Acute myocardial infarction		CAUSE OF DEATH (A) DUE TO Branched pneumonia (B) DUE TO confluent of all lobes (C)		INTERVAL BETWEEN ONSET AND DEATH 5-6 days 10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Oct. 8 1966 to Oct. 16 1966, that (I) (we) last saw the deceased alive on Oct. 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE K. B. Lee		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Oct. 16 '66	
23C. PHYSICIAN'S NAME (Type) Ki Bum Lee		23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/19/66		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Cem.	
24D. LOCATION (City, town, or county) (State) A. A. County Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 18 1966			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Walters Funeral Home - Balto., Md.			



40/04 22

WYOMING CO. Maryland

WYOMING CO. Maryland

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Greatly improved information

Preservation of the  
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H-620

66 10447

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10447

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT S. HARRIS, JR.

2. DATE AND HOUR PRONOUNCED DEAD

October 15, 1966 2:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6818 McClean Blvd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 7, 1937

9. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
10B. KIND OF BUSINESS OR INDUSTRY  
Hairdresser-Cedar Craft Studio of Hair Designing

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robert S. Harris, Sr.

14. MOTHER'S MAIDEN NAME

Anna Teves

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Frances Taormina Harris, wife, above

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Traumatic Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Wolfe & Biddle Streets

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

10 15 '66 1:40A

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparent auto-auto collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/15/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/18/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 18 1966

24B. NAME OF REGISTRAR

R. B. E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

ADDRESS

WALTER H. PETERSON

Released by the first Examiner 9:00 PM

Protebed and sign

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10448	
BIRTH NO. 66 10448		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Brown, Francis Earle	
2. DATE AND HOUR OF DEATH 10/13/66 7:15 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp. 38		A. STATE MD.		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 30 42		D. STREET ADDRESS (If rural, give location) 2604 Foerster Ave.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Mar. 21/1897	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Railroad Track Foreman	10B. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Mt. Airy, Carroll Cty., Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Brown		14. MOTHER'S MAIDEN NAME Alice Brown (Gaither)		ADDRESS 116 S. Hilton St. Balt., Md.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 705-09-0114		17. INFORMANT (Son) David C. Brown	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Acute myocardial infarction (B) DUE TO ACVD (C)		INTERVAL BETWEEN ONSET AND DEATH minutes months	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from D.O.A. 19 to 10/13 1966, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irvin M. Sopher		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/13/66	
23C. PHYSICIAN'S NAME (Type) Irvin M. Sopher		23D. ADDRESS M.D. University Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-17-66		24C. NAME OF CEMETERY or CREMATORY FAIRVIEW	
24D. LOCATION (City, town, or county) (State) Carroll Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 18 1966		25B. NAME OF REGISTRAR Robert E. Fairview	
25C. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.		25D. ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10449	
BIRTH NO. 66 10449		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Howard M. Huber</i>		2. DATE AND HOUR OF DEATH <i>10/17/66</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 S. B. G. N.</i>		A. STATE <i>MD.</i> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 24-07</i>			
		D. STREET ADDRESS (If rural, give location) <i>1701 Covington St</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>3-2-92</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Store Keeper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Owner</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Middleton</i>		14. MOTHER'S MAIDEN NAME <i>Doeg</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Family - Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>451X + 199.2</i>		CAUSE OF DEATH (A) DUE TO <i>Abdominal aneurysm Rupture</i> (B) DUE TO (C) <i>Carcinoma of Stomach 2 years</i> <i>Carcinoma of Bladder 2 years</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>October 19 64</i> to <i>Oct 16 19 66</i> , that (I) (we) last saw the deceased alive on <i>10/13/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Isaac Miller</i>				23B. DATE SIGNED <i>10/17/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Isaac Miller</i>				23D. ADDRESS <i>1225 So. Charles St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>15</i>		24B. DATE <i>10/19/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 18 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR ADDRESS <i>M. City 130 E. Foulke</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10450		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10450	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ELIZABETH C. MYERS		2. DATE AND HOUR OF DEATH Oct. 14, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 9 N. MILTON AVE		A. STATE MD. B. COUNTY BALTO			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO			
		D. STREET ADDRESS (If rural, give location) 9 N. MILTON AVE 21224			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-1-1915	9. AGE (In years last birthday) 51	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME WM. CARRIGAN		14. MOTHER'S MAIDEN NAME CAROLINE GRAULING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. ROBERT-L. MYERS	
				ADDRESS 9 N. MILTON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 170X I Cancer of Breast		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 1960 to October 14 1965, that (I) (we) last saw the deceased alive on October 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jason H. Gaskel		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Oct 15, 1966	
23C. PHYSICIAN'S NAME (Type) Jason H. Gaskel, M.D.		23D. ADDRESS 637 S. Conkling St. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-17-66		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
				24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Thelma Hoffmann	
				ADDRESS 3218 Hudson St	



Center of Research

Types

James H. Gaskel, M.D.  
James H. Gaskel

637 S. Conkling St. Baltimore

x

Oct 12, 1912

October 2

October 11



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 10451	
BIRTH NO. 66 10451				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) HENDERSON, SAMUEL	
2. DATE AND HOUR OF DEATH Oct. 16, 1966 12 <sup>00</sup> A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6318 Toone Street 21224	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-21-1889	9. AGE (In years lost birthday) 77	10. Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Charles				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-0201		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Cerebral Thrombosis 6yrs week (B) DUE TO Atherosclerotic Cardio Vascular Disease 10 yrs (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchitis				INTERVAL BETWEEN ONSET AND DEATH 6yrs	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-3-66 to 10-16-66, that (I) (we) last saw the deceased alive on 10-16-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Alexander Silverman M.D.				23B. DATE SIGNED 10-16-66	
23C. PHYSICIAN'S NAME (Type) Dr. Alexander Silverman				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10		24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR Robert E. Farkner		24F. FUNERAL DIRECTOR Walter G. Gabor, 1005 Dundalk Ave.	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

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BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 66 10452		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10452	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) ALVIN J. MASON		2. DATE AND HOUR PRONOUNCED DEAD October 14, 1966 1:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  19 South Calhoun Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 19 South Calhoun Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Nov. 21, 1903
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 62
11. BIRTHPLACE (State or foreign country) Orange Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A.J. Mason Sr.		14. MOTHER'S MAIDEN NAME Ella Clara Barnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/31/42-3/17/43		16. SOCIAL SECURITY NO. 213-01-4532	
17. INFORMANT Dwight L. Mason.		ADDRESS Arlington, Virginia	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A. Bronchopneumonia DUE TO B. Fatty Metamorphosis of Liver DUE TO C. Arteriosclerotic Cardiovascular Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/14/66			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Oct. 17, 1966	
23C. NAME of CEMETERY or CREMATORY National Memorial Park		23D. LOCATION (City, town, or county) (State) Falls Church, Virginia	
24A. DATE REC'D BY HEALTH DEPT. OCT 18 1966		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24C. FUNERAL DIRECTOR Everly-Wheatley Funeral Home, Virginia		24D. ADDRESS Alexandria, Virginia	

# VALLEY BOULDER

EXCULPENT

CHARTER

W. H. - 1871

1871 - 1872

1872 - 1873

1873 - 1874

1874 - 1875

1875 - 1876

1876 - 1877

1877 - 1878

1878 - 1879

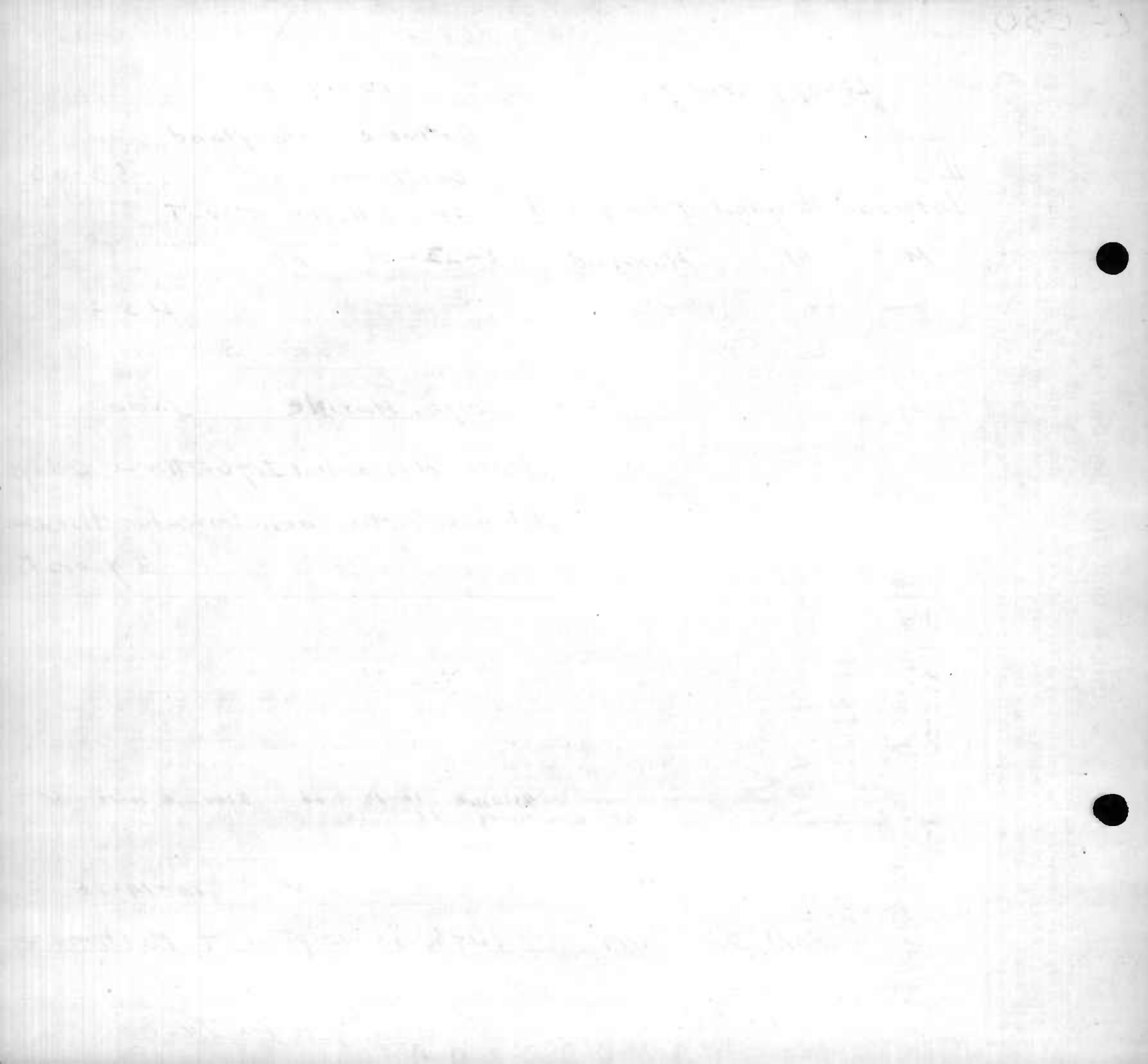
1879 - 1880

1880 - 1881

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10453				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10453	
1. NAME OF DECEASED (Type or Print) <b>Leroy, George</b>				2. DATE AND HOUR OF DEATH <b>10-17-66</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 Lutheran Hospital of Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore, Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>53-00</b> D. STREET ADDRESS (If rural, give location) <b>28 Blister Street</b> <b>21220</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3-23-00</b>	9. AGE (In years lost birthday) <b>66</b>	10. If Under 1 Yr. Months: Days: Hours: Min.		11. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assemblyman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>		11. BIRTHPLACE (State or foreign county) <b>Frostburg Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lance Leroy</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Richardson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-10-9196</b>		17. INFORMANT <b>Wife, Maxine</b>		ADDRESS <b>Same</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction 4 days</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>3 years +</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <b>Acute Myocardial Infarction 4 days</b> (B) <b>Atherosclerotic Cardiovascular disease</b> (C) <b>3 years +</b>			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes No.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4:30 a.m. 10-17 19 66</b> to <b>5:00 a.m. 10-17 19 66</b> , that (I) (we) last saw the deceased alive on <b>4:30 a.m. 10-17 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W. Kim</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-17-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>WON JA KIM</b>				23D. ADDRESS <b>Lutheran Hospital of Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-21-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Allengany Memorial Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Frostberg, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, MA</b>		25C. FUNERAL DIRECTOR <b>Lester J. Hanna 7401 Belair Rd</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10454				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10454	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mal B. Mulderry</i>				2. DATE AND HOUR OF DEATH <i>10-16-66 9 P</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>St Agnes Hosp</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 23-06</i>			
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) <i>401 Font Hill Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>Widowed</i>	8. DATE OF BIRTH <i>7-14-05</i>	9. AGE (In years lost birthday) <i>61</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife @ home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Oden Sweetland</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NE</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Elizabeth Mulderry</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>				CAUSE OF DEATH (A) <i>Coronary Thrombosis</i> DUE TO (B) <i>arteriosclerosis generalized</i> DUE TO (C) <i>Old Duodenal Ulcer History</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Few Minutes</i> <i>years.</i> <i>years</i>	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Jan. 1968</i> to <i>Oct 16, 1966</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Oct 14, 1966</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.							
23A. SIGNATURE <i>Abram Goldman</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10-17-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>ABRAM GOLDMAN</i>				23D. ADDRESS <i>4123 FREDERICK AV. Baltimore Md-29</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-20-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet Cms. Baltimore Md</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 18 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc</i>		ADDRESS <i>Baltimore Md</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10455		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10455	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Joseph Young</u>			Oct. 15, 1966 8:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> 48			A. STATE <u>Maryland</u> B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> 19-01		
			D. STREET ADDRESS (If rural, give location) <u>407 Gilmore ST (formerly Lake Drive Nursing Home (prior to admission))</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>3/12/77</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 16 3863</u>		17. INFORMANT ADDRESS <u>Lillian Daffner (daughter) 1606 Lemon ST.</u>	
18. <u>49.3 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Dehydration</u> DUE TO (B) <u>Pneumonia</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD, cerebrovascular insuff years</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 14, 1966</u> 19 to <u>Oct. 15, 1966</u> 19, that (I) (we) last saw the deceased alive on <u>Oct. 15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Michael Gould</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>10/15/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. MICHAEL GOULD</u>				23D. ADDRESS <u>MD GEN. Hosp. - Balto, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-19-66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Oakland Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John J. Gorman &amp; Son Inc. Balto, Md.</u>	

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 10456

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>QUEENITA Crowder (CRAWDER)</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>September 9, 1966 3:57 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1726 Linden Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>11/17/38</b>	9. AGE (In years, last birthday) <b>29</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>William Crowder</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Swinnie</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr Bryant Wall, Jr 1726 Linden Ave</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Old Myocardial Infarcts</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Bronchial Asthma</b>							INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Rudiger Breitenecker</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/10/66</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>10/15/66</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		24B. NAME OF REGISTRAR <b>R. E. F. Adams</b>		24C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		24D. ADDRESS <b>1206 W North Ave</b>	

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# WATLEY REPORT

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10457	
BIRTH NO. 66 10457		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Pidge Branhan		2. DATE AND HOUR OF DEATH October 17, 1966 7:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location) 906 St. Paul Street 21202		11. BIRTHPLACE (State or foreign country) Virginia	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-22-1884	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Winston Branhan		14. MOTHER'S MAIDEN NAME Irene Lena Knuckles		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 231-16-9814		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 181.0 I CAUSE OF DEATH CARCINOMA OF BLADDER (A) DUE TO Sepsis (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 YR. 1 WEEK.		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/14 1966 to 10/17 1966, that (I) (we) last saw the deceased alive on 10/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Swimmer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/17/66	
23C. PHYSICIAN'S NAME (Type) Dr. David Swimmer		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/20/66		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION Balto, Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 18 1966		24F. NAME OF REGISTRAR Wm. Cook-Brooks F. H. Balto. Md. 21202	
24G. DATE REC'D BY HEALTH DEPT. OCT 18 1966		24H. NAME OF REGISTRAR Wm. Cook-Brooks F. H. Balto. Md. 21202		24I. FUNERAL DIRECTOR 1217 St. Paul St. ADDRESS Wm. Cook-Brooks F. H. Balto. Md. 21202	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 10458		CERTIFICATE OF DEATH		Registered No. 66 10458	
1. NAME OF DECEASED (Type or Print) <b>Charles H. Chilcote, Sr.</b>						2. DATE AND HOUR OF DEATH <b>October 15, 1966</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 4105 Boarman Avenue</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4105 Boarman Ave.</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>March 13, 1905</b>		9. AGE (In years last birthday) <b>61</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Underwriter</b>						11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William M. Chilcote</b>						14. MOTHER'S MAIDEN NAME <b>Sarah C. Dillehunt</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>						16. SOCIAL SECURITY NO. <b>212-09-2796</b>		17. INFORMANT ADDRESS <b>Ruth N. Chilcote 4105 Boarman Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>CORONARY THROMBOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>CHRONIC PULMONARY EMPHYSEMA</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>6-20 19 57</b> to <b>10-14 19 66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>10-14 19 66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Samuel P. Scalia</b> M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-17-66</b>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D. <b>2 SHERWOOD AVE. BALTIMORE MD 21208</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-18-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Ellsworth Chavest</b>		25C. FUNERAL DIRECTOR <b>Ellsworth Chavest</b>		ADDRESS <b>4600 Liberty Hghts. Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10459				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10459	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Kathern E. Flora</b>				2. DATE AND HOUR OF DEATH <b>Oct. 15, 1966 2 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE, MARYLAND 53-00</b> D. STREET ADDRESS (If rural, give location) <b>6830 WINDSOR MILL ROAD</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-16-10</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM KEYSER</b>			14. MOTHER'S MAIDEN NAME <b>BLANCHE BROWN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>213-10-5227</b>		17. INFORMANT ADDRESS <b>C. Lambert Flora 6830 Windsor Mill Road</b>		
18. <b>710.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <b>cardiac arrhythmia</b> DUE TO  (B) <b>scleroderma</b> DUE TO  (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept 29 1966</b> to <b>Oct 10 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct 15 1966</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M.M. Buckley</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/15</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.M. BUCKLEY</b>				23D. ADDRESS <b>1620 McIlhenny St</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-19-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		25B. NAME OF REGISTRAR <b>John E. Fink</b>		25C. FUNERAL DIRECTOR <b>Ellsworth Amos</b>		ADDRESS <b>4600 Liberty Hghts.</b>	

22

and

1/2

1/2

1/2

1/2

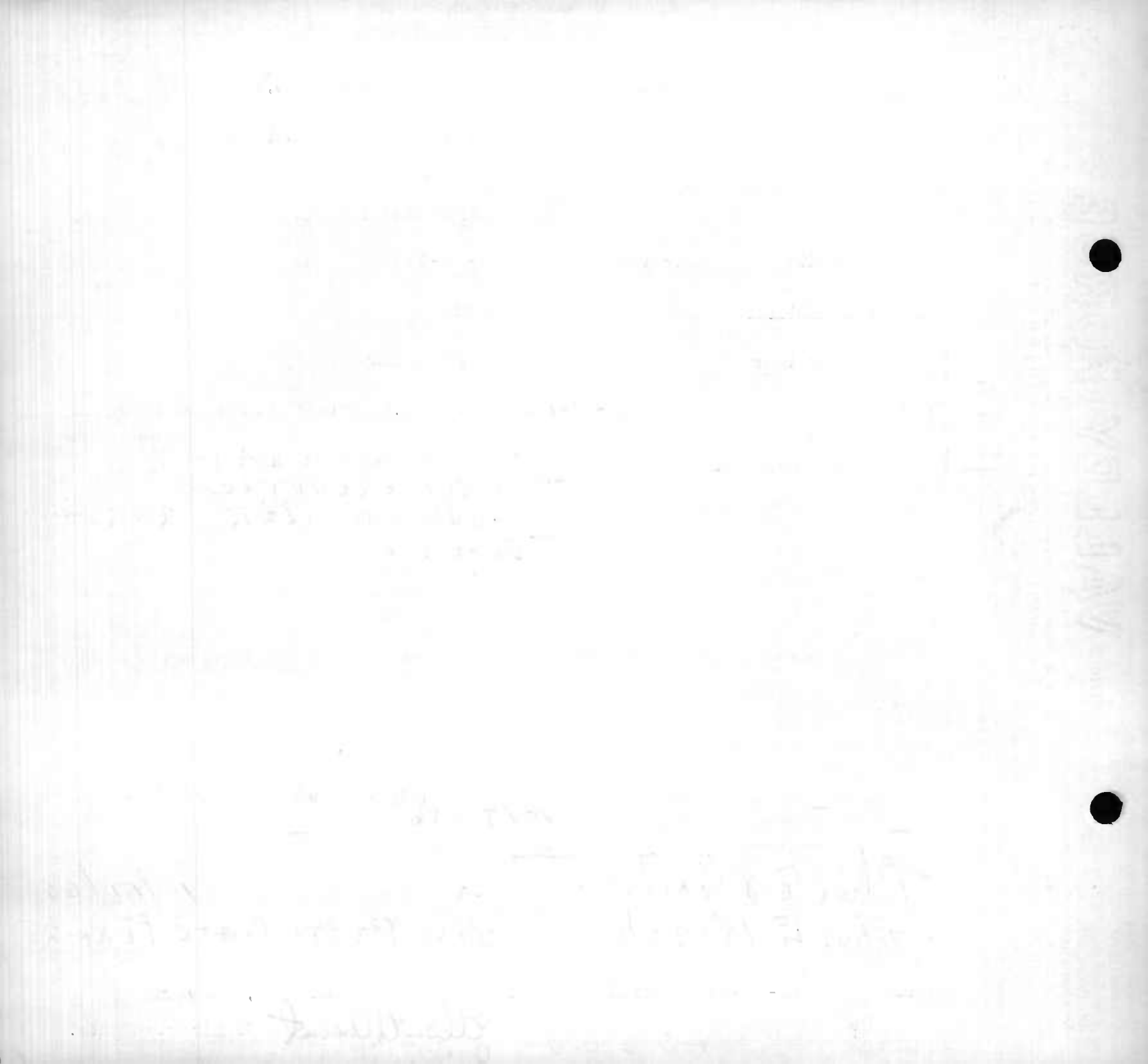
1/2

1/2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10460</b>	
BIRTH NO. <b>66 10460</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>John Sherman Gardiner</b>		2. DATE AND HOUR OF DEATH <b>October 16, 1966</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>512 Woodside Road</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>512 Woodside Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8-26-1885</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bakery Consultant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert Gardiner</b>		14. MOTHER'S MAIDEN NAME <b>Emma Barr</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>495-07-7394</b>		17. INFORMANT <b>Maria E. Gardiner</b> ADDRESS <b>512 Woodside Road</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>443X I</b>		CAUSE OF DEATH (A) <b>HYPERTENSIVE CATH- TERIC CEROTIC</b> (B) <b>CARDIOVASCULAR</b> (C) <b>Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS +</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JAN. 19 60</b> to <b>10/16 19 66</b> , that (I) (we) last saw the deceased alive on <b>10/17 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thos E Roach</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/17/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>		23D. ADDRESS <b>5550 BARTON NATL PIKE-28</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-19-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Roach</b>		25C. FUNERAL DIRECTOR <b>Ellsworth</b>		ADDRESS <b>4600 Liberty Hgts.</b>	



VJ-1420 66 10461

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 10461 Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEROY WILLIS

2. DATE AND HOUR PRONOUNCED DEAD

October 15, 1966

8:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

North Carolina

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Reidsville

D. STREET ADDRESS (If rural, give location)

309 Mulberry St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 17, 1923

9. AGE (In years last birthday)

43

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Caswell Co., N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Sidney L. Willis

14. MOTHER'S MAIDEN NAME

Annie L. Redd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. E9036 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Cranio-cerebral injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Brentwood Avenue & Lanval Street

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)  
10 15 '66 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently Fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/16/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal

23B. DATE

10/18/66

23C. NAME of CEMETERY or CREMATORY

Greenview

23D. LOCATION

(City, town, or county) (State)

Reidsville

N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 18 1966

Arlington Phillips 1727 N. Main

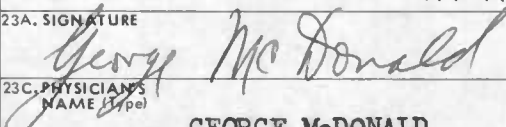
Received of  
Mr. J. H. Smith  
the sum of \$100.00  
for rent of premises  
situated at No. 123  
Main St. N.Y.C.

John F. Smith  
123 Main St.  
N.Y.C.

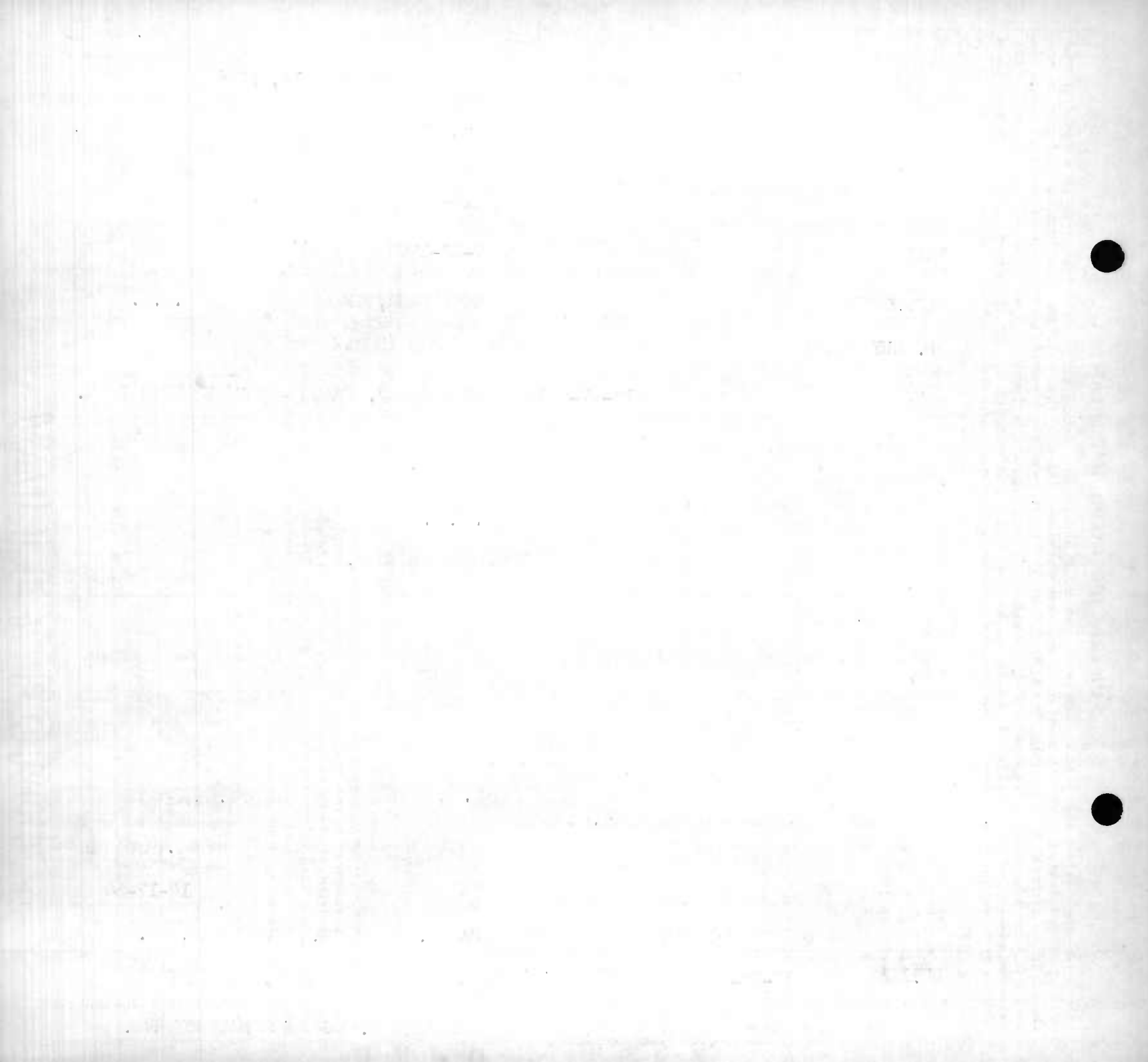
Witness my hand and seal  
this 1st day of May 1911  
at New York City

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <span style="font-size: 1.2em;">66 10462</span>		CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">66 10462</span>	
1. NAME OF DECEASED (Type or Print) <b>MARCELLUS GUY BRAGG</b>						2. DATE AND HOUR OF DEATH <b>OCTOBER 15, 1966</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>507 CUMBERLAND STREET</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>507 CUMBERLAND STREET</b>			
5. SEX <b>MALE</b>		6. RACE <b>COLORED</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>2-22-1900</b>		9. AGE (In years last birthday) <b>66</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINOTYPIST</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CORSICANA, TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>M. GUY BRAGG</b>						14. MOTHER'S MAIDEN NAME <b>SARAH EUGRAM</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-01-5568</b>		17. INFORMANT <b>JULIETTE J. BRAGG - 507 CUMBERLAND ST.</b>			
18. <b>177X I</b> CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  <b>None</b>						(A) <b>Carcinoma, prostates</b> DUE TO <b>With boney metastases</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
						(B) <b>A.H.C.V</b> DUE TO		<b>?</b>	
						(C) <b>Fistula in ano, old</b>		<b>?</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 9, 1966</b> 19 to <b>Oct. 6, 1966</b> 19, that (I) (we) last saw the deceased alive on <b>Oct. 6, 1966</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>Medical exam. notified</b>									
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) <b>GEORGE McDONALD</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-17-66</b>	
24A. BURIAL CREMATION, (Specify) <b>BURIAL</b>						24B. DATE <b>10-19-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>						25B. NAME OF REGISTRAR <b>Charles R. Law</b>		25C. FUNERAL DIRECTOR <b>CHARLES R. LAW 802 MADISON AVE.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>									



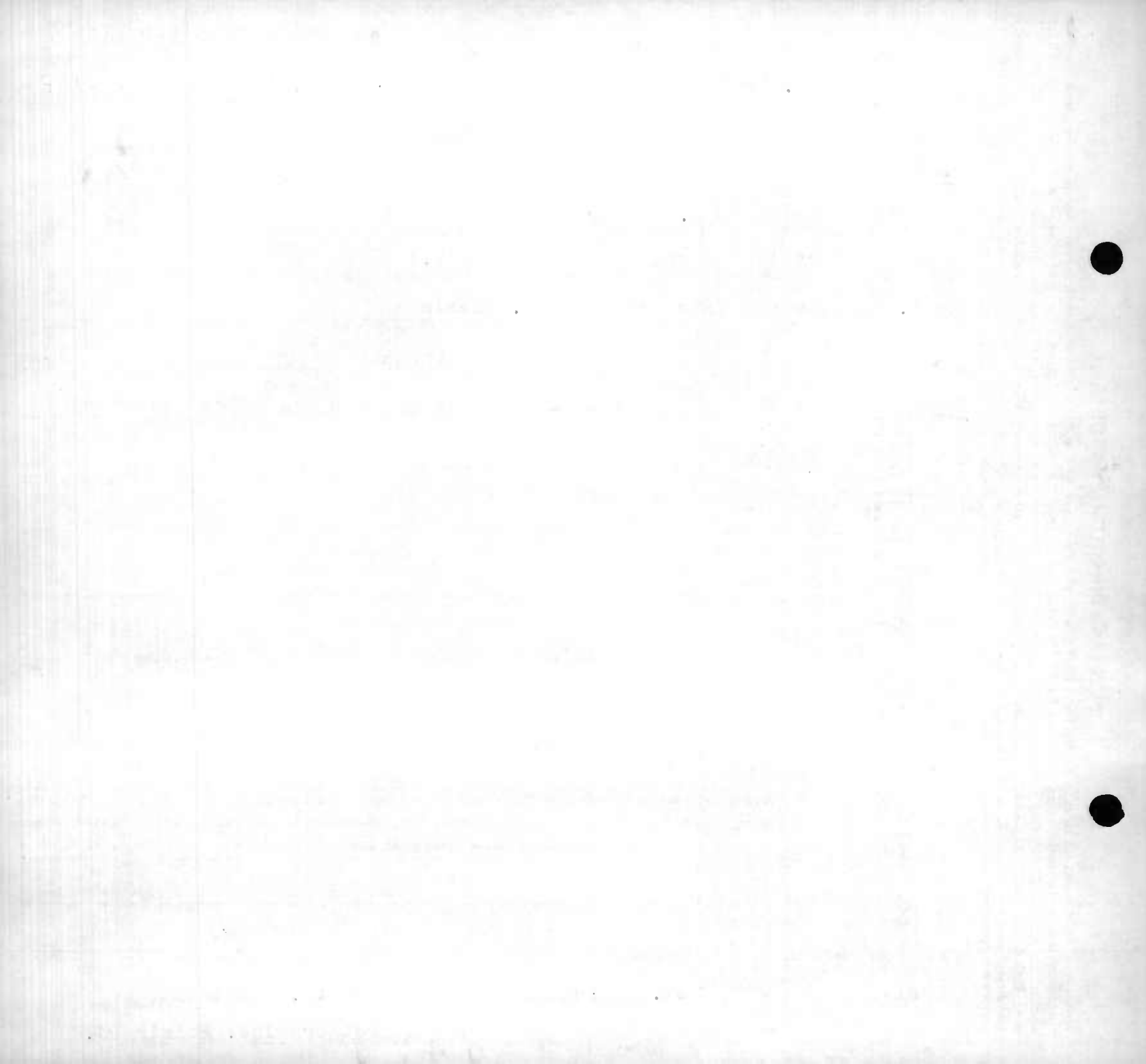




# FUNERAL DIRECTOR: IMPORTANT

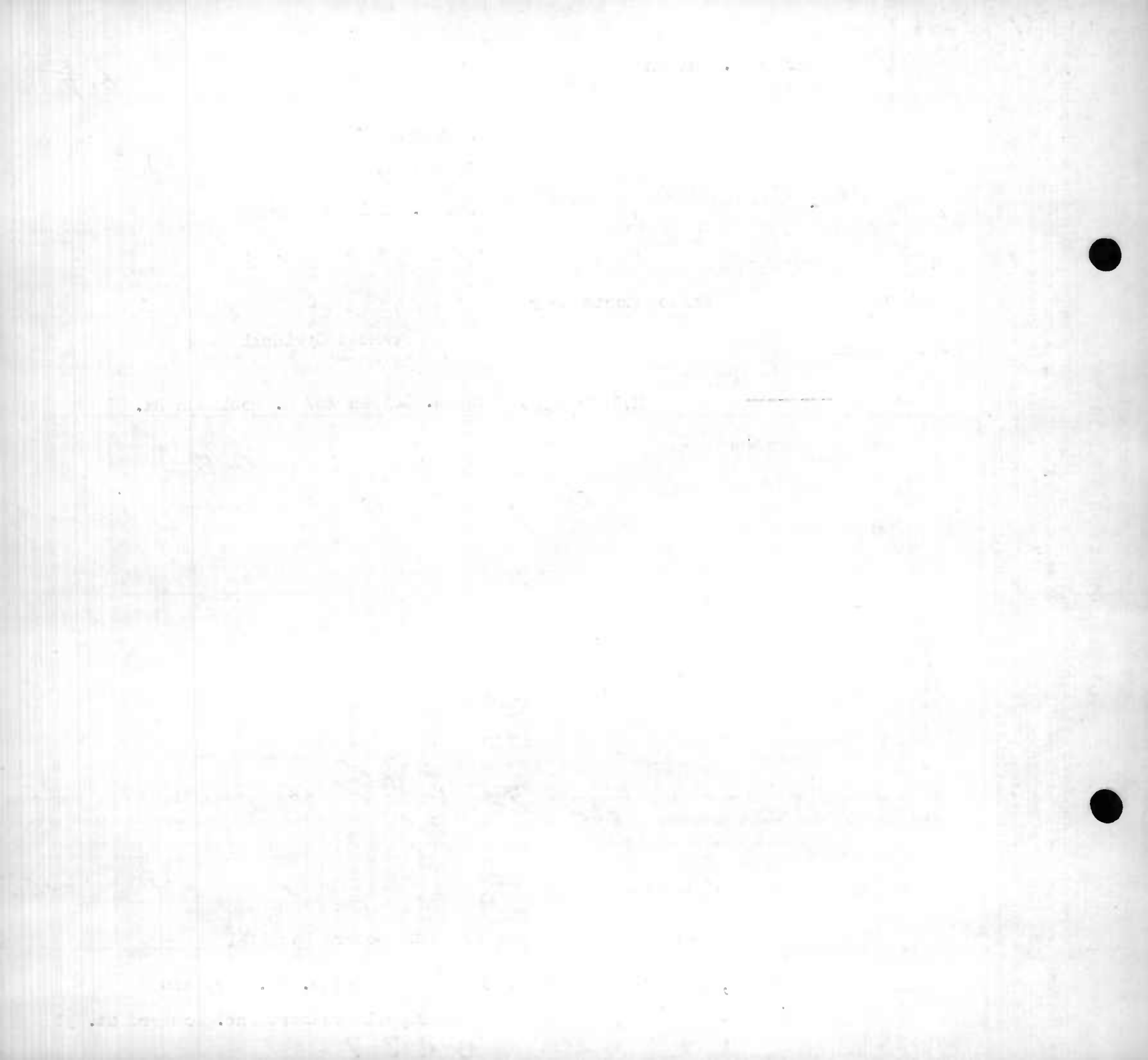
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10463		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10463	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Peter B. Boris		2. DATE AND HOUR OF DEATH Oct 17, 1966 1 6:47 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 99 Union Memorial Hosp. (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY XX Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-06 D. STREET ADDRESS (If rural, give location) 6404 Old Harford Road			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 17, 1888	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec. Secretary		10B. KIND OF BUSINESS OR INDUSTRY Bickford Restur.		11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob Boris		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 216-05-2839		17. INFORMANT ADDRESS Alexandra Boris 6404 Old Harford	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) Arteriosclerotic heart disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH immediate 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to 09-13-1966, that (I) (we) last saw the deceased alive on 09-13-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard V. Frazer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) C. Richard V. Frazer		23D. ADDRESS M.D. 205 Med Apts B-17, room 1 nd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/20/66		24C. NAME OF CEMETERY or CREMATORY St. Andrews Cemetery	
24D. LOCATION Balto, Maryland		24E. DATE REC'D BY HEALTH DEPT. OCT 18 1966			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Dippel Brothers Inc. Belair Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10464</u>	
BIRTH NO. <u>66 10464</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <u>Bertha R. Leiben</u>		2. DATE AND HOUR OF DEATH <u>Oct 15, 1966</u> <u>6:30</u> M.	
(Type or Print) <u>LEIBEN, BERTHA</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Franklin Square Hospital</u>		A. STATE <u>Maryland</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>267 S. Robinson Street</u>			
5. SEX <u>9</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>2/14/1910</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto Sports Wear</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Novak</u>		14. MOTHER'S MAIDEN NAME <u>Frances Cywinski</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-6087</u>		17. INFORMANT <u>John W. Leiben</u> ADDRESS <u>267 S. Robinson St.</u>	
18. <u>157X I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO <u>Widespread metastasis</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO <u>probable Ca of pancreas</u> <u>18 months</u>			
ANTECEDENT CAUSES		(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Malnutrition &amp; dehydration</u>					
19A. DATE OF OPERATION <u>1</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Oct 11/66</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1,</u> 19 <u>66</u> to <u>June 29</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. K. Kim</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>Oct 15, 1966</u>		
23C. PHYSICIAN'S NAME (Type) <u>Kim</u>		23D. ADDRESS <u>Franklin Square Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct 19, 66</u>	24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1966</u>	25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>	25C. FUNERAL DIRECTOR ADDRESS <u>The Dippel Brothers Inc. Lombard St. 31</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10465	
BIRTH NO. 66 10465		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Coker Sylvester</i>		2. DATE AND HOUR OF DEATH <i>10-17-66 10:10 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <i>MD</i> B. COUNTY <i>X</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Bolton Hill Nursing Home</i>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 6-05</i>	
D. STREET ADDRESS (If rural, give location) <i>1837 Mullikin Court</i>		5. SEX <i>M</i> 6. RACE <i>negro</i> 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>4-9-1907</i> 9. AGE (In years last birthday) <i>59</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lawrence S.C.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Coker Willis</i>		14. MOTHER'S MAIDEN NAME <i>Johnson Georgianna</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Agnes Coker</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>177X I</i>		CAUSE OF DEATH (A) DUE TO <i>metastatic carcinoma prostate</i> (B) DUE TO <i>malnutrition</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>7-6 mo</i> <i>7-6 mo</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-4-66</i> to <i>10-17-66</i> , that (I) (we) last saw the deceased alive on <i>10-17-66</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. Nakagawa</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10-17-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>H. NAKAGAWA</i>		23D. ADDRESS <i>521 W. Lexington St #1</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 21/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Greeny Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>A.D. County Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 15 1966</i>		25B. NAME OF REGISTRAR <i>E. E. E. E.</i>	
25C. FUNERAL DIRECTOR <i>Ellen E. E. E.</i>		25D. ADDRESS <i>McCarroll</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10466				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10466	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED <b>PASTERNAK, JOSEPHINE</b>				2. DATE AND HOUR OF DEATH <b>10-15-66 1145 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>UNIV. HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE, Md</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>CROWNSVILLE STATE HOSP</b> B. COUNTY <b>ANNE ARUNDEL COUNTY</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>MARYLAND</b> D. STREET ADDRESS (If rural, give location) <b>38</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>10/31/79</b>	9. AGE (In years last birthday) <b>87</b>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>J.S. KRAKOWSKI</b>				14. MOTHER'S MAIDEN NAME <b>ELIZ. - KRAKOWSKI -</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NR</b>			16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Anthony Pasternak, 109 Carvel Beach Rd., Pasadena, Md.</b>		
18. <b>5410 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>SEPSIS.</b>				CAUSE OF DEATH (A) DUE TO <b>WOUND INFECTION -</b> (B) DUE TO <b>BLEEDING PEPTIC ULCER 14 days.</b> (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD</b>			
19A. DATE OF OPERATION <b>10-4-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BLEEDING DODGICAL ULCER</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? <b>NA.</b>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>NA.</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>10-4-66 11:30 AM</b> to <b>19</b> , that (2) (we) last saw the deceased alive on <b>10-15-66 1145 AM</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) <b>did</b> (did not) view the body after death.							
23A. SIGNATURE <b>Robert M. Beazley</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-15-66.</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT M. BEAZLEY</b>				23D. ADDRESS <b>Univ. Hospital, Balto Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 18, 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Mary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgwy., Baltimore</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 86 10467	
BIRTH NO. 66 10467		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Agnes T. Sica</i>		2. DATE AND HOUR OF DEATH <i>10/16/66 7:05 M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE, 6</i>		D. STREET ADDRESS (If rural, give location) <i>6408 BROOKS AVE.</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>4-15-20</i>	9. AGE (In years last birthday) <i>46</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>PAUL LAPLANCHAE</i>		14. MOTHER'S MAIDEN NAME <i>Mary VIOLA Bowie</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-22-0467</i>		17. INFORMANT <i>Mr. Louis Sica</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Hepatic insufficiency c h/o chr. glomerulonephritis, proth. haemorrhagic diathesis, c from sep. and acute renal insufficiency</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>Many years</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>10/16/66</i> to <i>10/16/66</i> and that (I) (we) lost saw the deceased alive on <i>10/16/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <i>N. Fedson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/16/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. D. N. FEDSON</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/20/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 18 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>		25D. ADDRESS			

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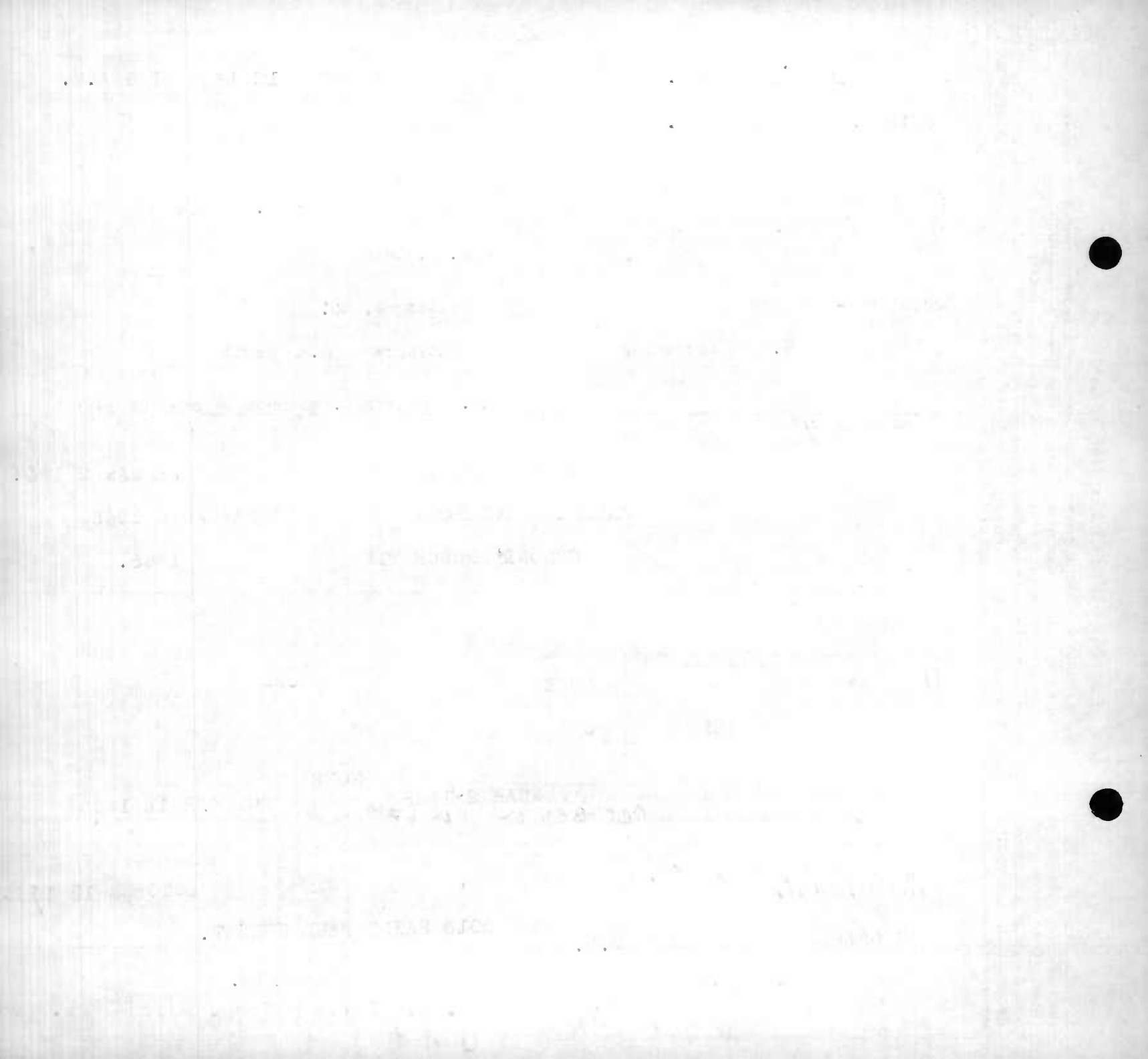
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 10468</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 10468</span>	
1. NAME OF DECEASED (Type or Print) <b>EDITH V. PICKERING.</b>			2. DATE AND HOUR OF DEATH <b>OCTOBER 12 1966 AT 6 A.M.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <b>3313 DORCHESTER ROAD.</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3313 Dorchester Rd. 15</b>		
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>Jan. 5, 1890</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary - Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Vernon G. Pickering</b>			14. MOTHER'S MAIDEN NAME <b>Florence R. Hurtt</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. Mortimer D. Roxbrough same address</b>		
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC MYOCARDITIS</b> DUE TO <b>ARTERIOR SCLEROSIS</b> DUE TO <b>CHRONIC BRONCHITIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>JANUAR 2 1965</b> <b>JANUAR 2 1965</b> <b>1965.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>NONE</b>		
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>NONE</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NONE</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NONE</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>	21C. WHERE DID INJURY OCCUR? <b>NONE</b>		
21D. TIME OF INJURY (APPROX.) <b>NONE</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>NONE</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>JANUAR 2 1965</b> to <b>OCTOBER 12 1966</b> and that (I) (we) last saw the deceased alive on <b>OCTOBER 12 1966</b> at <b>6 AM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Charles P. Clautice</i> M.D.			23B. DATE SIGNED <b>OCTOBER 12 1966</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR CHARLES P CLAUTICE M.D.</b>			23D. ADDRESS M.D. <b>3013 SAINT PAUL STREET.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/15/1966</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Mausoleum</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		25B. NAME OF REGISTRAR <i>Wm. J. Ticker</i>	25C. FUNERAL DIRECTOR <b>Wm. J. Ticker &amp; Sons. North &amp; Pa. Ave</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 10469	
BIRTH NO. 66 10469		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH <b>14 October 66 2:08 AM</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Frances Jones</b>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <b>University Hospital, Baltimore, Md.</b> <small>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</small>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>			
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>	
8. DATE OF BIRTH <b>2-16-16</b>		9. AGE (In years last birthday) <b>50</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>not known (Domestic)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Isaac Jones</b>			
14. MOTHER'S MAIDEN NAME <b>Georgia Green</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>218-26-9130</b>		17. INFORMANT (Florence Smith 130 Obery Ct Annapolis, Md) <b>Old Chart</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Renal failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Surgical correction, thoracic aortic aneurysm</b>		<b>1 week</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Haemomediastinum; Cardiac failure</b>		<b>25+ yrs</b>			
19A. DATE OF OPERATION <b>14 Oct. 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Thoracic aortic aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>4 Oct 1966</b> to <b>14 Oct. 1966</b> that (2) (we) last saw the deceased alive on <b>14 Oct 1966</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>C. J. Beitel M.D.</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>14 Oct. 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. J. Beitel</b>		23D. ADDRESS M.D. <b>University Hospital, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/17/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Brewer Hill cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>Oct 18 1966</b>			
25B. NAME OF REGISTRAR <b>G. E. Hacke</b>		25C. FUNERAL DIRECTOR <b>111 Annapolis, Md</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 10470					CERTIFICATE OF DEATH		Registered No. 66 10470		
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
				KATIE C. ARMSTRONG			OCTOBER 9, 1966 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE				
					B. COUNTY				
00 2236 CEDLEY STREET, 21230					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE BALTIMORE 25-33				
					D. STREET ADDRESS (If rural, give location)				
					2236 CEDLEY AVENUE				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
FEMALE	WHITE	WIDOWED		4-1-1891	75			VIRGINIA	
						12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
NEWTON H. CARPENTER					MALINDA ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				215-07-2898		HARDESTY FUNERAL HOME, ANNAPOLIS, MARYLAND			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH				
					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) DUE TO				
					Queenoma of right breast				
					(B) DUE TO				
					Metastatic Ca.				
					(C) DUE TO				
					6 months				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Jan 2 1945 to Oct 9 1966, that (I) (we) last saw the deceased alive on Oct 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
Paul Schonfeld								10/11/66	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
PAUL SCHONFELD					2301 ANNAPOLIS ROAD				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		10-12-66		LOUDON PARK CEMETERY		BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
OCT 18 1966		R. E. Fairbank		HARDESTY FUNERAL HOME, ANNAPOLIS, MARYLAND					

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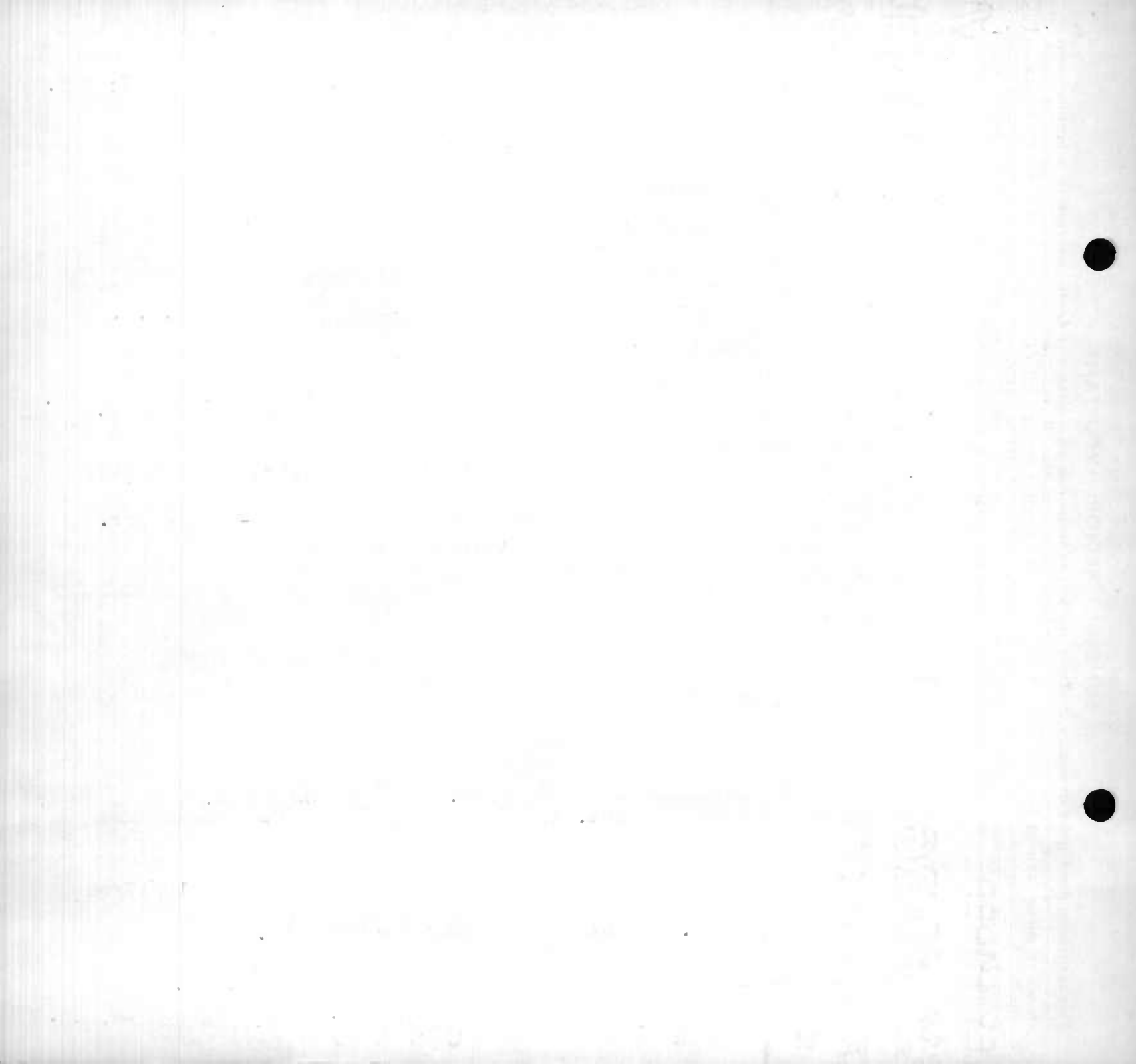
Page 1 of 1



# FUNERAL DIRECTOR: IMPORTANT

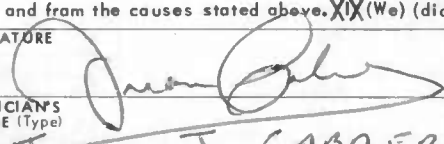
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10471</u>	
BIRTH NO. <u>66 10471</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARY C. OTREMBA</u>		2. DATE AND HOUR OF DEATH <u>10/14/66</u> <u>7:45 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE <u>Maryland</u>			
(If not in hospital or institution, give street address or location)		B. COUNTY			
<u>532 S. Ellwood Avenue</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
<u>00</u>		D. STREET ADDRESS (If rural, give location) <u>532 S. Ellwood Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>7-10-1894</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joseph Stanislawski</u>		14. MOTHER'S MAIDEN NAME <u>Michaelena</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-20-8908</u>		17. INFORMANT <u>Michael Otremba, 532 S. Ellwood Ave. Baltimore, Md.</u>	
18. <u>420.1 I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSES		(B) DUE TO <u>Arteriosclerotic Cardio-vascular Disease</u>		<u>5 yrs.</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Apr.</u> 19 <u>55</u> to <u>Oct.</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 14</u> 19 <u>66</u> and that in (my) ( <del>the</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Clarence W. LeDoux</u> M.D.				23B. DATE SIGNED <u>10/17/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Clarence W. LeDoux</u> M.D.				23D. ADDRESS <u>3023 Eastern Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/18/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Sacred Heart Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Nicholas T. Matthews</u>		25C. FUNERAL DIRECTOR <u>3023 Eastern Ave., Baltimore, Md.</u>	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10472</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>66 10472</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <b>BROWN, LOUISE R. (MISS)</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>OCTOBER 16, 1966 11:30A.M.</b>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b> <div style="text-align: center;"> <b>ST. AGNES HOSPITAL</b>  <small>(If not in hospital or institution, give street address or location)</small>  <b>WILKENS &amp; CATON AVES.</b>  <b>BALTO., MD. 21229</b> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b>		
<b>5. SEX</b> <b>FEMALE</b> <b>6. RACE</b> <b>WHITE</b>			<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <b>SINGLE</b>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>RICHARD DEC'D</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>EVELYN (REESE) DEC'D</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>220206280</b>		
<b>17. INFORMANT</b> <b>WILKENS &amp; CATON AVE</b> <b>ST. AGNES RECORDS - BALTO., MD. 21229</b>			<b>18. ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>NEPHROSCLEROSIS AND UREMIA</b> ANTECEDENT CAUSES <b>DIABETES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
<b>19A. DATE OF OPERATION</b> <b>2</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>YES</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <b>OCTOBER 1, 1966</b> to <b>OCTOBER 16, 1966</b> , that <input checked="" type="checkbox"/> <b>(we)</b> last saw the deceased alive on <b>OCTOBER 16, 1966</b> and that in <input checked="" type="checkbox"/> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> <b>(We)</b> (did) <input checked="" type="checkbox"/> <b>view</b> the body after death.					
<b>23A. SIGNATURE</b>  <b>JUAN J. CABRERA</b> M.D.				<b>23B. DATE SIGNED</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>JUAN J. CABRERA</b> M.D.		<b>23D. ADDRESS</b> <b>WILKENS &amp; CATON AV</b> <b>ST. AGNES HOSPITAL - BALTO., MD. 21229</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>10-19-1966</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Linthicum Chapel</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Clarksville, Md</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 18 1966</b>			
<b>25B. NAME OF REGISTRAR</b> <b>F.C. Higinbotham</b>		<b>25C. FUNERAL DIRECTOR</b> <b>F.C. Higinbotham, Ellicott City, Md</b>			

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

DATE: [Illegible]

BY: [Illegible]

DATE: [Illegible]

RE: [Illegible]

DATE: [Illegible]

RE: [Illegible]

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RE: [Illegible]

DATE: [Illegible]

L-553

66 10473

BALTIMORE CITY HEALTH DEPARTMENT

66 10473

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANNIE

2. DATE AND HOUR PRONOUNCED DEAD

JULIA

ANN

LAMONT

October 13, 1966 5:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4200 Elderon Avenue

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
ADDRESS OR LOCATION)

12-15-66

4200 Elderon Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

May 19<sup>th</sup> 19039. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Hattie Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

239-10-8107

17. INFORMANT

Hamilton &amp; Home N. Carolina

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/14/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/17/66

23C. NAME of CEMETERY or CREMATORY

Cumberland Co. N.C.

23D. LOCATION

Goldboro

N.C.

24A. DATE REC'D BY HEALTH DEPT.

OCT 18 1966

24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

Harry Hamilton N. Carolina

ADDRESS

V.S. 153

12-15-66

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <u>66 10474</u>	
BIRTH NO. <u>66 10474</u>											
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Wilmore, Earl</u>						2. DATE AND HOUR OF DEATH <u>10/15/66</u> <u>13 35</u> <u>P</u> <u>M</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1805 E. 28TH STREET</u>					
5. SEX <u>MALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>DIVORCED</u>		8. DATE OF BIRTH <u>11-15-13</u>		9. AGE (In years last birthday) <u>52</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dan Wilmore</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>219-05-7521-5</u>		17. INFORMANT <u>Carl Collier</u>				ADDRESS	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Massive Acute Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <u>Massive Acute Myocardial Infarction</u> DUE TO (B) <u>Hours</u> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>10/15</u> 19 <u>66</u> to <u>10/15</u> 19 <u>66</u> , that (2) (we) last saw the deceased alive on <u>10/15</u> 19 <u>66</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.											
23A. SIGNATURE <u>Murray A. Katz</u> M.D.								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/15/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MURRAY A. KATZ</u>								23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>10-21-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cornet Cent</u>				24D. LOCATION (City, town, or county) (State) <u>Lanham Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR <u>Chapman Wilson</u>			
								ADDRESS <u>1000 Brantley Ave</u>			

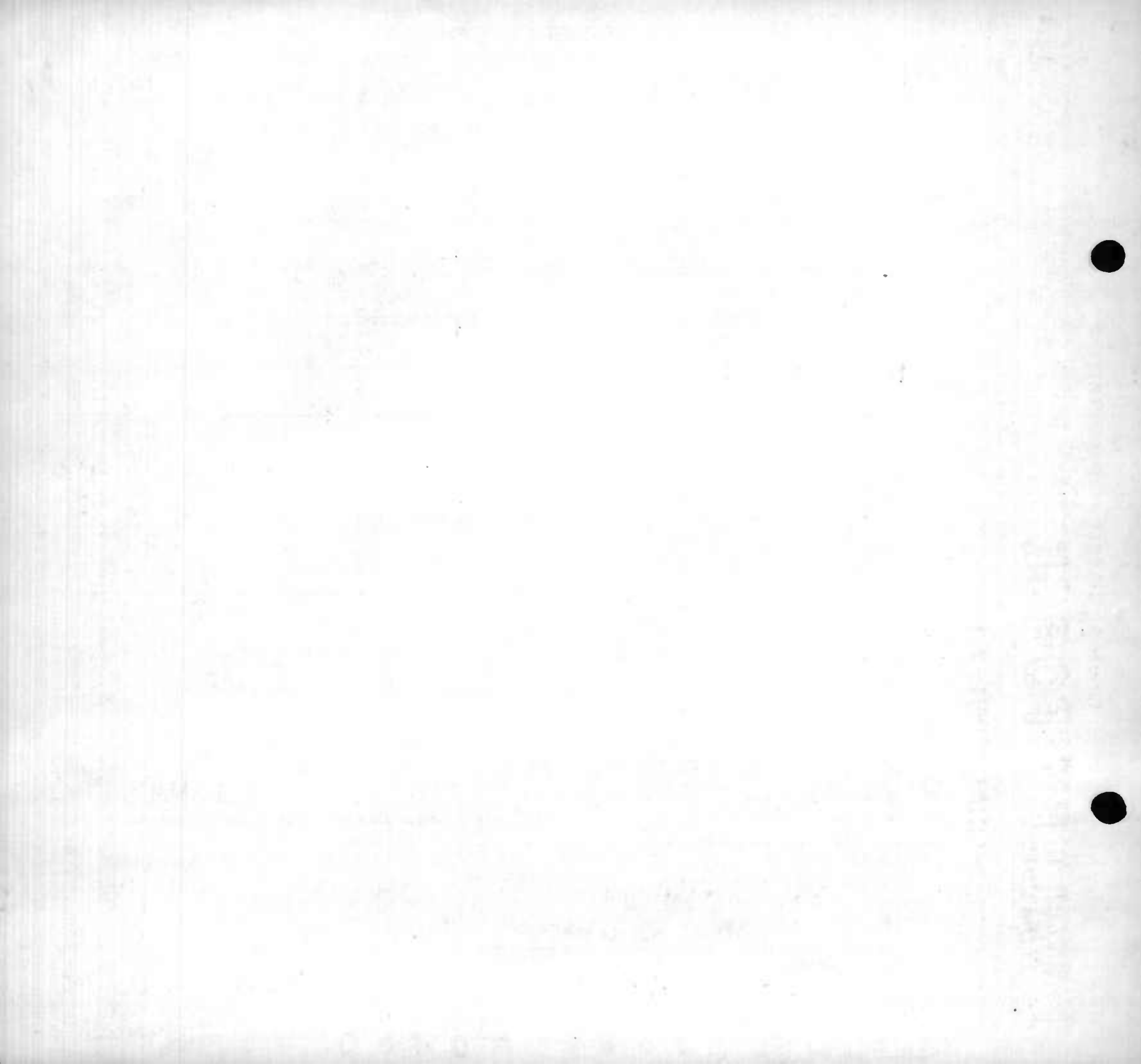




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

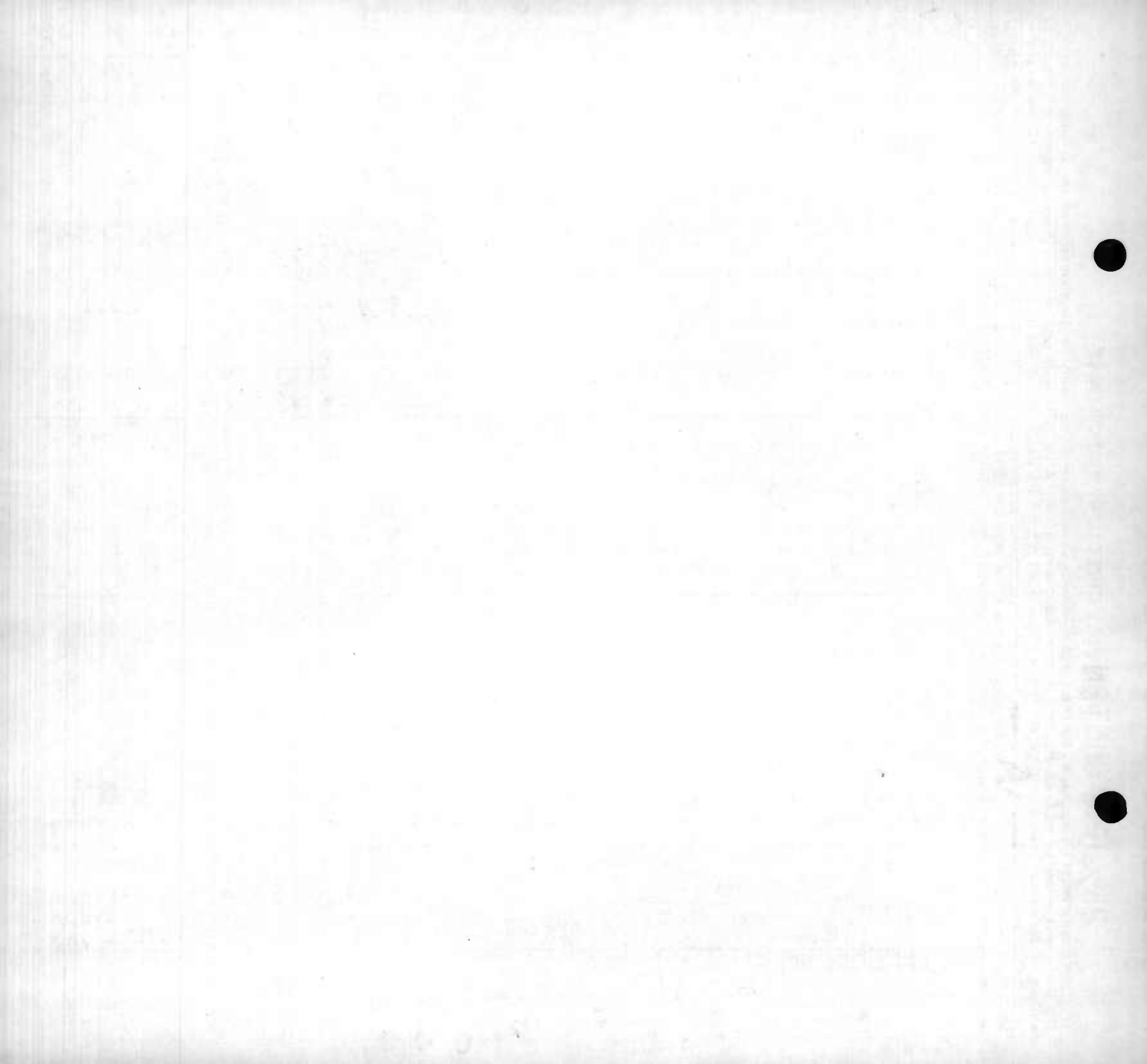
BIRTH NO. 66 10475				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10475	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Albert Gregory</i>				2. DATE AND HOUR OF DEATH <i>10/14/66 11:15 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>17-01</i> D. STREET ADDRESS (If rural, give location) <i>637 W. FRANKLIN STREET 21201</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1-10-00</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ROBERT GREGORY</i>				14. MOTHER'S MAIDEN NAME <i>MARY STOKES</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Blanche Gregory</i>		ADDRESS <i>Same</i>	
18. <i>593X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>Renal failure &amp; uremia</i> <i>Cardiac Arrest</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased (from <i>10/14 1966</i> to <i>10/14 1966</i> ) that (I) (we) last saw the deceased alive on <i>Oct 14 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Sherrard L. Hayes</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/14</i>	
23C. PHYSICIAN'S NAME (Type) <i>SHERARD L. HAYES M.D.</i>				23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-20-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Pine Forge Crt</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD Va</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John 1000 Brant type</i>		25C. FUNERAL DIRECTOR ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10476		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10476	
1. NAME OF DECEASED (Type or Print) <b>WELDON WREN</b>			2. DATE AND HOUR OF DEATH <b>10/15/66 2<sup>15</sup> A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Md GEN Hosp. LINDEN AVE BALTO., Md. 21201</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 2-0-07</b> D. STREET ADDRESS (If rural, give location) <b>211 MT. HOLLY ST.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-27-92</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>W. WREN.</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-01-2300</b>		17. INFORMANT <b>Weldon Wren Jr.</b> ADDRESS <b>Kenneth R Koskinen, M.D.</b>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARCINOMA of LIVER, METASTASES</b>			INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/19</b> 19 <b>66</b> to <b>10/15</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/15</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth R Koskinen</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/15/66</b>
23C. PHYSICIAN'S NAME (Type) <b>KENNETH R KOSKINEN M.D.</b>			23D. ADDRESS <b>6408 MARIETTA AVE BALTO., MD 21214</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 19, 1966</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Chas. O. Walcott 1000 Bentley Ave.</b>	



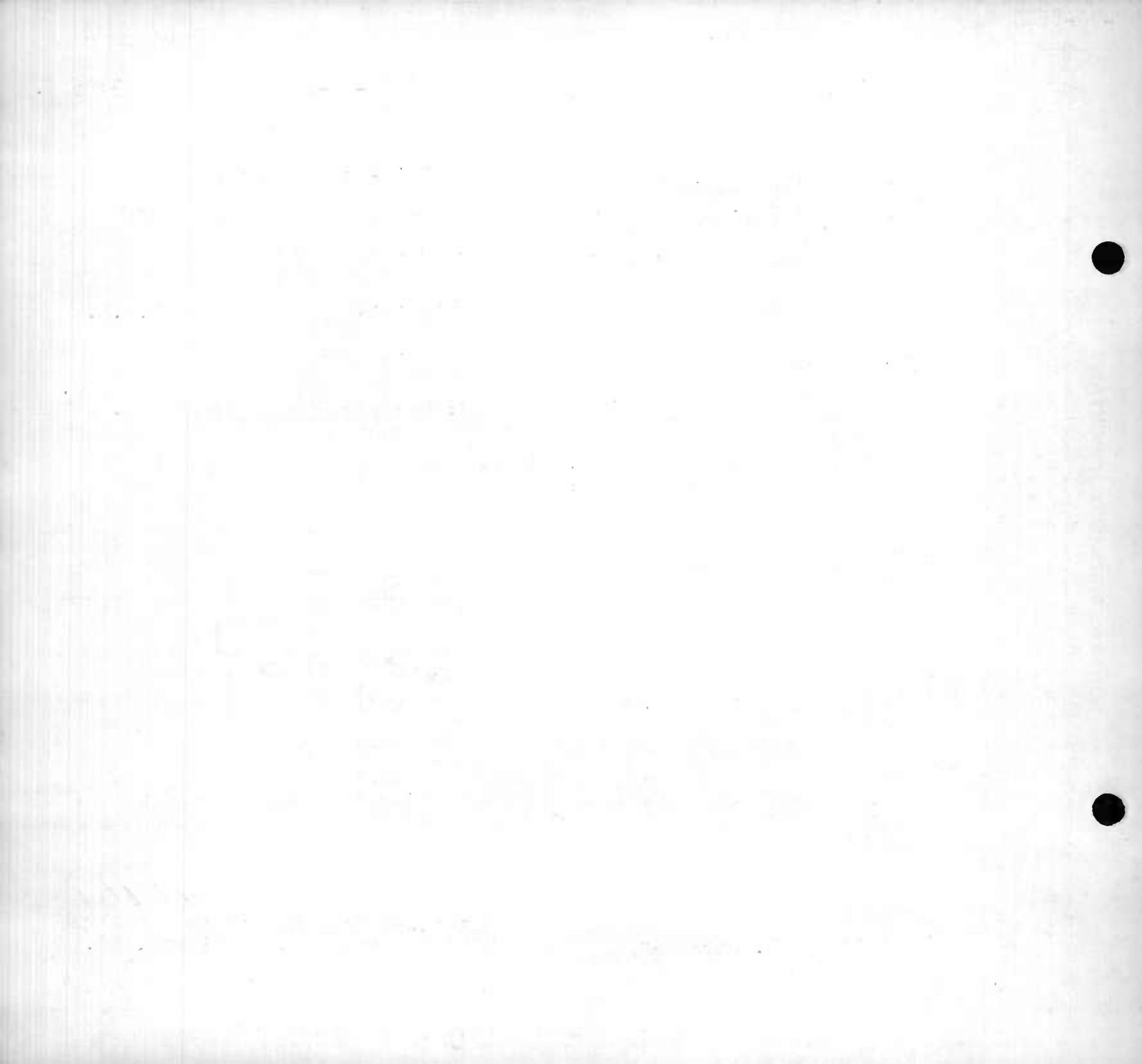
## CERTIFICATE OF DEATH

Registered No. 66 10477

BIRTH NO. 66 10477		M.E. CASE NO.	
1. NAME OF DECEASED (Type of Print) <b>William Cator</b>		2. DATE AND HOUR OF DEATH <b>10-16-66 3:05 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1903 Ashland Avenue 21205</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5/22/01</b>
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pump Cator</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Harris</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-01-1578</b>	
17. INFORMANT <b>BCH: Records</b>		ADDRESS <b>4940 Eastern Ave. Baltimore, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>1621 I</b> <b>BRONCHOGENIC CARCINOMA</b>		CAUSE OF DEATH (A) DUE TO <b>1 year</b> (B) DUE TO (C) DUE TO	
19. DATE OF OPERATION <b>10/16/66</b>		20. AUTOPSY? (Yes or No) <b>No</b>	
21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. TIME OF INJURY (Month) (Day) (Year) (Hour)		24. HOW DID INJURY OCCUR?	
25. I certify that (I) (this hospital) attended the deceased from <b>9/22/66</b> to <b>10/16/66</b> and that (I) (we) lost saw the deceased alive on <b>10/16/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
26. SIGNATURE <b>Jeffery D. Aaronson</b>		27. DATE SIGNED <b>10/18/66</b>	
28. PHYSICIAN'S NAME (Type) <b>Jeffery D. Aaronson</b>		29. ADDRESS <b>Baltimore City Hospitals # 21224 4940 Eastern Ave. Baltimore, Md.</b>	
30. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		31. DATE <b>10-20-66</b>	
32. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cmt</b>		33. LOCATION <b>Brooklyn Md</b>	
34. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		35. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
36. FUNERAL DIRECTOR, ADDRESS <b>1000 Brantly Ave</b>			

FUNERAL DIRECTOR: IMPORTANT

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM EUGENE ADAMS

2. DATE AND HOUR PRONOUNCED DEAD

October 18, 1966

7:52 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

543 Park Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

10/1/23

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Chemical Operater

10B. KIND OF BUSINESS OR INDUSTRY

Chemical Manufacturer

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alonzo Eugene Adams

14. MOTHER'S MAIDEN NAME

Lallie Clyde Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. II

16. SOCIAL  
SECURITY NO.

230-12-6652

17. INFORMANT

Steacler Funeral Home

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

October 18, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/21/66

23C. NAME of CEMETERY or CREMATORY

Oakwood Cemetery

23D. LOCATION

(City, town, or county)

Pulaski, Virginia

24A. DATE REC'D BY HEALTH DEPT.

OCT 18 1966

24B. NAME OF REGISTRAR

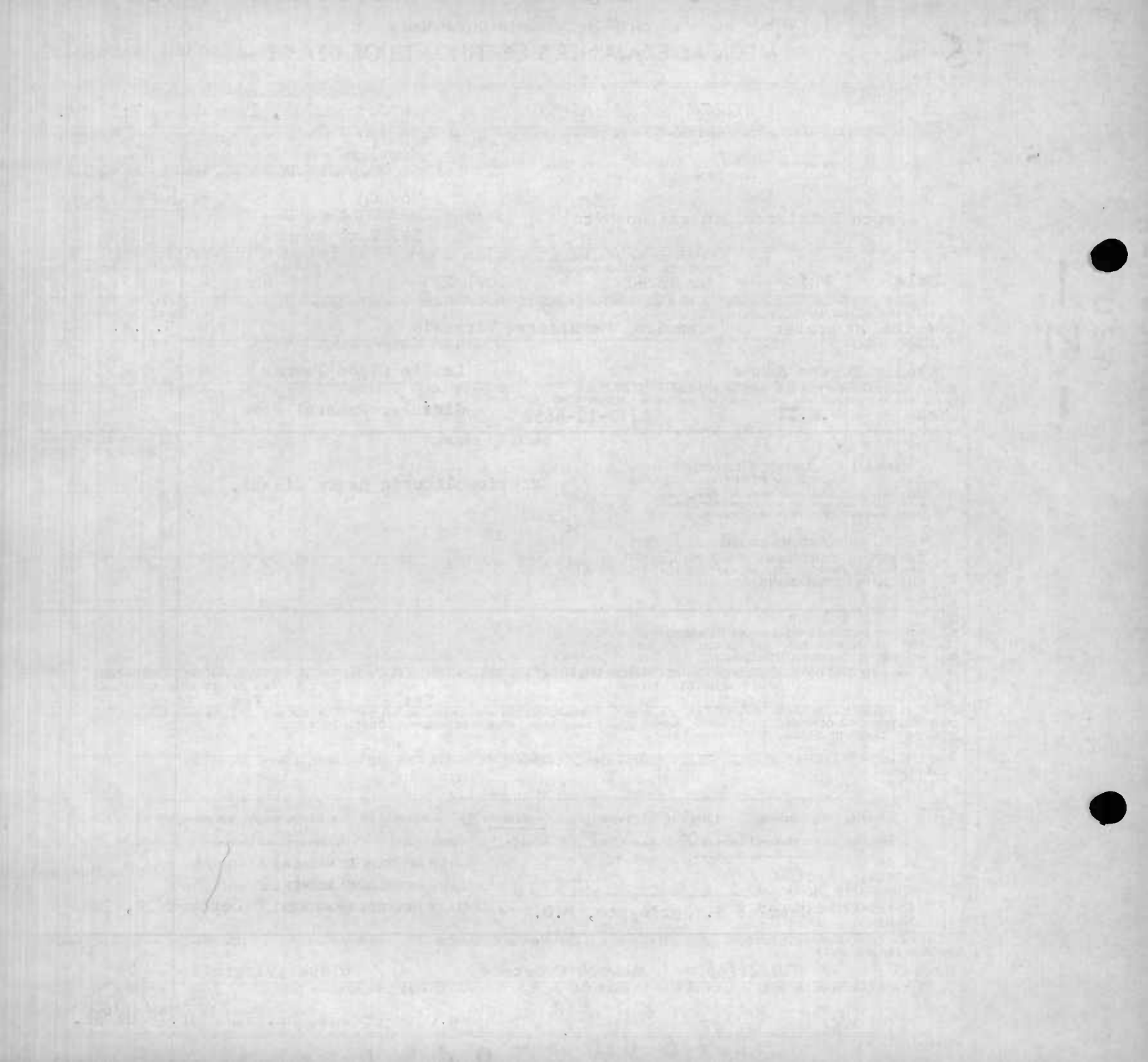
Robert E. Fairbank

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. 1217 St. Paul St.

ADDRESS  
BALTO. Md. 21207



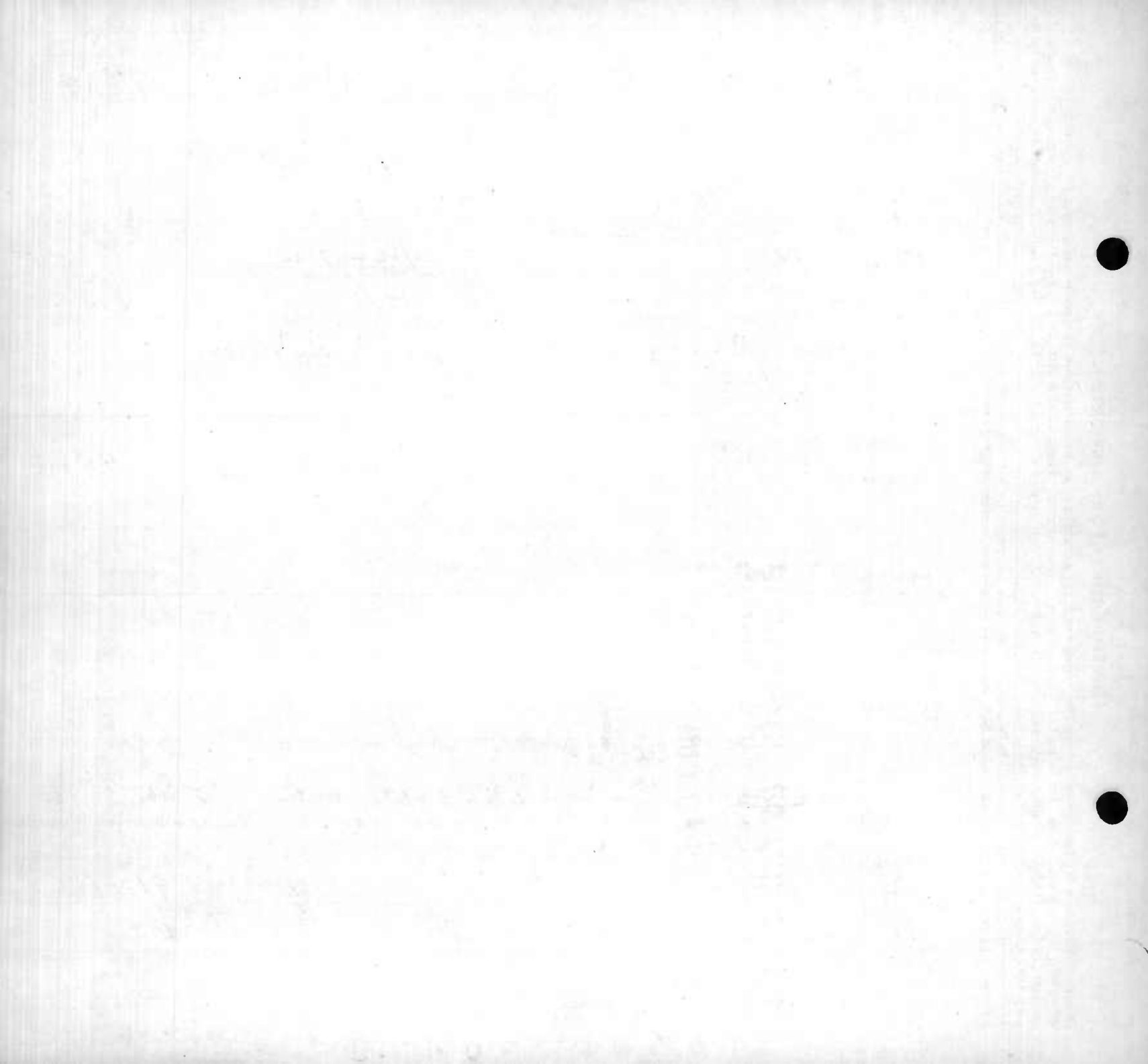




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

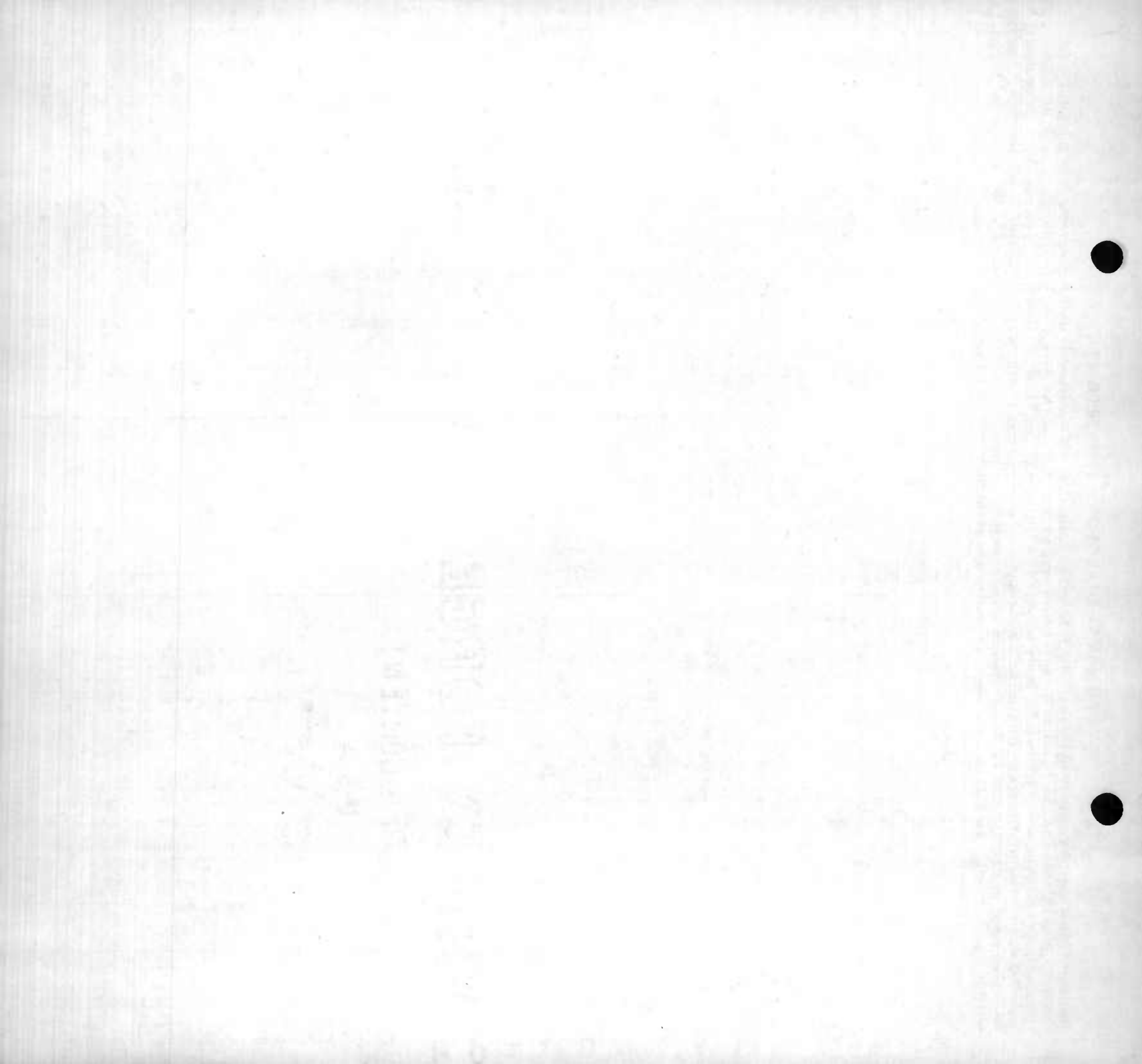
BIRTH NO. 66 10479		Baltimore CITY HEALTH DEPARTMENT		Registered No. 66 10479	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby boy Curry		2. DATE AND HOUR OF DEATH 9/30/66 7:15 am M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hosp 38		A. STATE Md. B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 17-03			
		D. STREET ADDRESS (If rural, give location) 725 George St #1			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9/30/66-63 am	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Herman Curry		14. MOTHER'S MAIDEN NAME Virgil Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Imaturity		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 45 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6:30 am 9/30 19 66 to 7:15 am 9/30 19 66, that (I) (we) last saw the deceased alive on 9/30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. Gary Benfield				23B. DATE SIGNED 9/30/66	
23C. PHYSICIAN'S NAME (Type) D. GARY BENFIELD				23D. ADDRESS UNIVERSITY HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) 10-6-66		24B. DATE 10-6-66		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL SERVICE MORTUARY SERVICE - BCI		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1966		25B. NAME OF REGISTRAR John B. E. Taylor		25C. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 10480</span>	
BIRTH NO. <span style="float: right;">66 10480</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>BABY BRIGGS B</i>		2. DATE AND HOUR OF DEATH <i>9/29/66 - 5:30 PM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>27-16</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIV. Hospital</i> <i>38</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO MD</i>			
		D. STREET ADDRESS (If rural, give location) <i>(UNIV. Hospital) 2915 Woodland Ave</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>9/29/66</i>	9. AGE (In years last birthday) <i>3X Mths</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <i>6:00</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>WILLIAM ELIJAH BRIGGS</i>		14. MOTHER'S MAIDEN NAME <i>DUVALL - 2915 Woodland Ave</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>E.S. TOKAR MD UNIV. Hosp</i>	
18. <i>776X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>IMMATURITY</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>6 Hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <i>9/29/66 11:30 AM</i> to <i>9/29/66 5:30 PM</i> that (1) (we) lost saw the deceased alive on <i>5:30 PM 9/29/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Elliot S. Tokar</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/29/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>ELLIOT S. TOKAR</i>		M.D. <i>UNIV. Hospital</i>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>10-6-66</i>		24C. NAME of CEMETERY or CREMATORY <i>ANATOMIC BOARD OF MARYLAND</i>	
24D. LOCATION (City, town, or county)		24E. HOPKINS MEDICAL SCHOOL		24F. MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-21349 66 10481		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10481	
M.E. CASE NO.		CERTIFICATE OF DEATH		2	
1. NAME OF DECEASED (Type or Print) Baby Boy Briggs "A"		2. DATE AND HOUR OF DEATH 9/29/66 12 noon M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIV HOSP. 38		A. STATE Md. B. COUNTY Baltimore			
5. SEX Male		6. RACE C		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Newborn	
8. DATE OF BIRTH 9/29/66		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY U.S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Univ. Md. Hosp. - Md.	
13. FATHER'S NAME Wm. Elijah Briggs		14. MOTHER'S MAIDEN NAME Margaret Luvinia Duwall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mother - Same	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) Immaturity			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/29/66 19 to 9/29/66 19, that (I) (we) last saw the deceased alive on 12:20 9/29/66 19 and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elliott S. Tokar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/25/66	
23C. PHYSICIAN'S NAME (Type) ELLIOT S. TOKAR		23D. ADDRESS UNIVERSITY HOSPITAL ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/16/66		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

THE UNIVERSITY OF CHICAGO

1  
G-432

66 10482

BALTIMORE CITY HEALTH DEPARTMENT

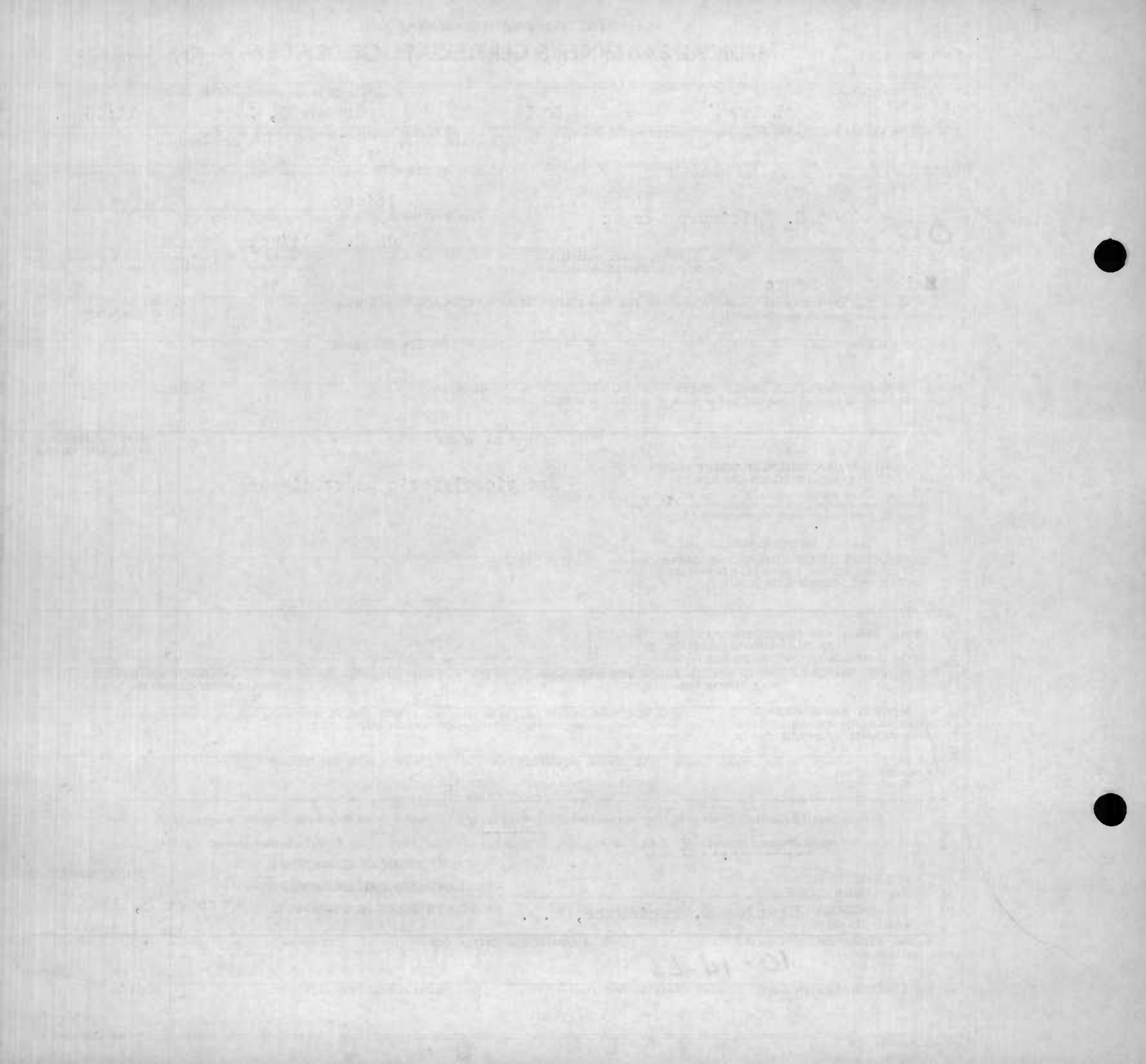
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10482

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>ALBERT GOLDSTEIN</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 3, 1966 11:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>1305 E. Baltimore Street</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1305 E. Baltimore Street</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>64</b>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. CAUSE OF DEATH <b>42010 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 3, 1966</b>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE <b>10-14-66</b>	23C. NAME OF CEMETERY or CREMATORY
23D. LOCATION (City, town, or county) (State)		<b>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	24C. FUNERAL DIRECTOR ADDRESS







**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10483</u>	
BIRTH NO. <u>66-19982</u>		66 10483		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby girl of Helen Stratton</u>		2. DATE AND HOUR OF DEATH <u>September 23, 1966</u> <u>9:20p</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1512 N. Fremont Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>Sept. 23, 1966</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>15</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Mannie Powell</u>			14. MOTHER'S MAIDEN NAME <u>Helen Stratton</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Helen Stratton-mother</u>		ADDRESS <u>same</u>
18. <u>773.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HYALINE MEMBRANE</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>PREMATURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>September 23, 19 66</u> to <u>September 23, 19 66</u> , that (I) (we) last saw the deceased alive on <u>September 23, 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Carl H. Sand</u>				23B. DATE SIGNED <u>September 23, 1966</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>10-13-66</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u>	
25D. ADDRESS <u>MORTUARY SERVICE - BCHD</u>					

Copy

## CERTIFICATE OF DEATH

Registered No.

66 10484

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10484		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10484	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>James M. WALSH</i>		2. DATE AND HOUR OF DEATH <i>6:50 AM 10/2/66</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITAL</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>6 South Broadway 21231</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>DIVORCED</i>	8. DATE OF BIRTH <i>6-30-04</i>	9. AGE (In years last birthday) <i>62 57</i>	(If Under 1 Yr. Months: Days: Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Walsh</i>		14. MOTHER'S MAIDEN NAME <i>Virginia</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>002.11</i>		CAUSE OF DEATH (A) DUE TO <i>Pulmonary Embolism</i> (B) DUE TO <i>Congestive Heart Failure</i> (C) DUE TO <i>Chronic Lung Disease AND T.B.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>? 3-4 days</i> <i>? 1+ years</i> <i>10 years</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>9/27</i> 19 <i>66</i> to <i>10/2</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>10/2</i> 19 <i>66</i> and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David Swimmer MD</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10-2-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>David Swimmer</i>		M.D. 23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>10-10-66</i>		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <i>UNIVERSITY MEDICAL SCHOOL</i> <i>MORTUARY SERVICE - BCHD</i>	

0000

W. White. Dated 2-20-04 27

G-460

66 10485

BALTIMORE CITY HEALTH DEPARTMENT

66 10485

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY

GAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

September 28, 1966 4:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

00 3619 Falls Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3619 Falls Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

E974X1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia  
DUE TO(B) Hanging.  
DUE TO

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

3619 Falls Road

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9

27

'66

P

m.

21E. INJURY OCCURRED

WHILE AT  
WORK

□

NOT WHILE  
AT WORK

□

21F. HOW DID INJURY OCCUR?

Hanged self.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

10/11/66

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 18 1966

Robert E. Feltner, M.D.

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66-210766 10486		CERTIFICATE OF DEATH		66 10486	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		GARY BOY BYAS		9-25-66 11:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
38 UNIVERSITY HOSPITAL		Md.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1151 N. Carey St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZENSHIP (If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.)
M	NEGRO	NEVER MARRIED	9-25-66		2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WERRY BYAS			ANNIE HICKS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		PREMATURITY		3 hrs	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. A. McClain III				9/25/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
C. A. McClain III		ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		10/6/66		JOHNS HOPKINS MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 18 1966		Robert E. Farley		MORTUARY SERVICE - BCHD	

52/50

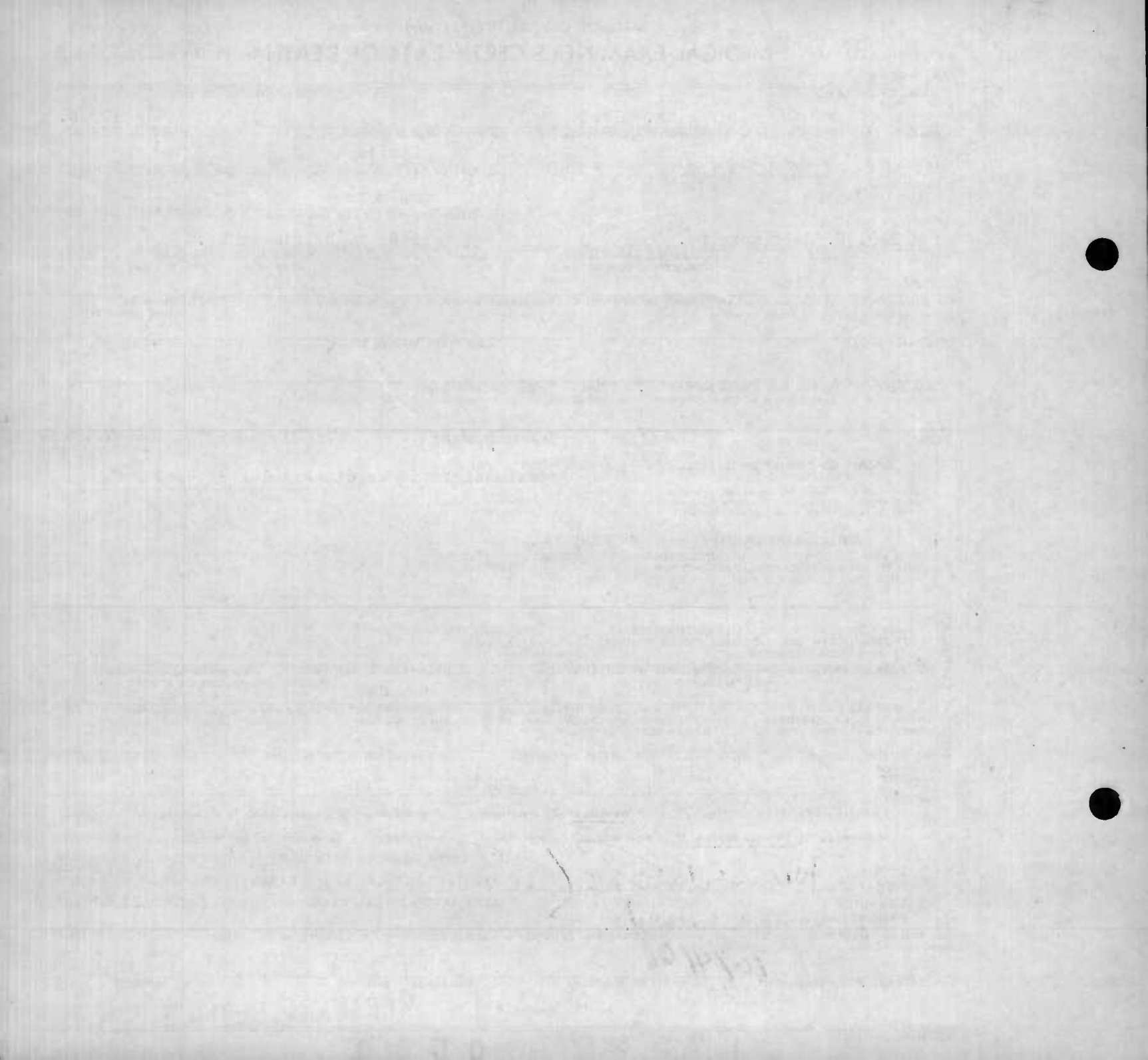


I-240

## BALTIMORE CITY HEALTH DEPARTMENT

66 10487

BIRTH NO. 66 10487		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 10487	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
George A. Ikel		9/22/66 11:20 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
00 3401 E. Baltimore St.		C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 3401 E. Baltimore St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
male	white		9. AGE (In years last birthday) 51
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO			
(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME OF CEMETERY or CREMATORY
		10/4/66	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
OCT 18 1966		Robert E. Farley, M.D.	UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-18468 66 10488		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10488	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Baby Boy Lynett			2. DATE AND HOUR OF DEATH 5 PM - 9-21-66		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIV. HOSPITAL BAC TO. MD			A. STATE B. COUNTY University Hosp. Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BAC TO MD 10-02		
			D. STREET ADDRESS (If rural, give location) 805 McLean Ct. LUMBAARD GREENGSS. Mc ALBERT CT.		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9-5-66	9. AGE (In years last birthday) 26	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE MATTHS			14. MOTHER'S MAIDEN NAME MARCIA LYNCH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ES. TOKARNO		ADDRESS UNIV. HOSP.
18. 34031 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) DUE TO Septicemia + Meningitis		INTERVAL BETWEEN ONSET AND DEATH 10 Hours
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(B) DUE TO		
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-5-66 19 to 9/21/66 19, that (I) (we) last saw the deceased alive on 9-21-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elliot S. Tokar			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-21-66
23C. PHYSICIAN'S NAME (Type) ELLIOT S. TOKAR			23D. ADDRESS UNIVERSITY HOSP. BALTIMORE, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/4/66		24C. NAME of CEMETERY or CREMATORY	
				24D. LOCATION (City, town, or county) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR ADDRESS	
				JOHNS HOPKINS MEDICAL SCHOOL	
				MORTUARY SERVICE - BCHD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66-1773 66 10489</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 10489</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Baby Girl Robinson</b>		2. DATE AND HOUR OF DEATH <b>9/10/66 10:15 a. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital Baltimore, Md.</b>		A. STATE <b>MD.</b> B. COUNTY <b>Balt.</b> C. CITY OR TOWN <b>Baltimore</b> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <b>1653 N. Smallwood St.</b>			
5. SEX <b>F</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>never married</b>	8. DATE OF BIRTH <b>9/10/66</b>	9. AGE (In years last birthday) <b>0</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>0 0 2 4</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Ronald Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Leslie Finch</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Leslie F. Robinson, 1653 N. Smallwood</b>	
18. <b>776X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Immaturity</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs - 4 min.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/10</b> 19 <b>66</b> to <b>9/10</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jane C. McCaffrey</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/10/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jane C. McCaffrey</b>		23D. ADDRESS			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>10/6/66</b>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <b>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1966</b>		25B. NAME OF REGISTRAR <b>R. E. F.</b>		25C. FUNERAL DIRECTOR ADDRESS	

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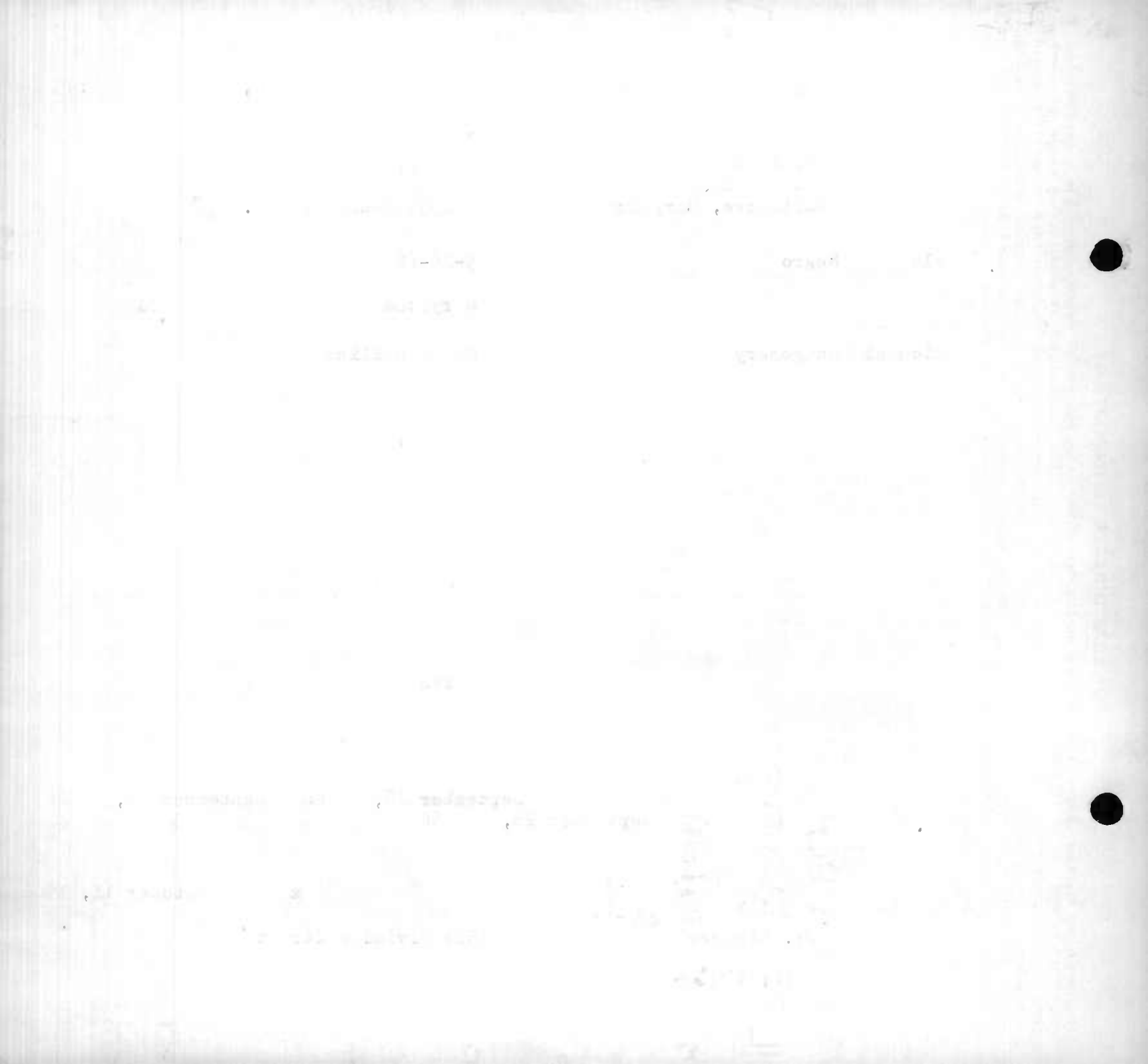
22/10/01



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <u>66-20866 66 10491</u>		CERTIFICATE OF DEATH		Registered No. <u>66 10491</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby of Marie Rollins</u>						2. DATE AND HOUR OF DEATH <u>September 28, 1966</u> <u>1:45 AM.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39 Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-01</u> D. STREET ADDRESS (If rural, give location) <u>1539 Mountmore Ct.</u>			
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>9-26-66</u>		9. AGE (In years last birthday) <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>15</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Montgomery</u>						14. MOTHER'S MAIDEN NAME <u>Marie Rollins</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Atelectasis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>September 26, 1966</u> to <u>September 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>September 28, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>O. H. Saunders</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>October 11, 1966</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Lizarro</u>		23D. ADDRESS <u>1514 Division Street</u>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10/13/66</u>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR		ADDRESS			
<b>OCT 18 1966</b> <b>UNIVERSITY MEDICAL SCHOOL</b> <b>MORTUARY SERVICE - BCH</b>									



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 10492	
BIRTH NO. 66 10492		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STRACK, Charles		2. DATE AND HOUR OF DEATH 9/27/66 3:00 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md. B. COUNTY BALT.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
33 Johns Hopkins Hospital		D. STREET ADDRESS (If rural, give location)		1015 Homewood AVE	
5. SEX male	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MAR.	8. DATE OF BIRTH 10/06/26	9. AGE (In years last birthday) 40	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Edward Strack		14. MOTHER'S MAIDEN NAME Emma Allen		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) SUBARACHNOID HEMORRHAGE DUE TO (B) HYPERTENSION DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 55 hrs. ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/24 19 66 to 9/27 19 66, that (I) (we) last saw the deceased alive on 9/27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. H. Brown, III		23B. DATE SIGNED 9/27/66		23C. PHYSICIAN'S NAME (Type) C. H. Brown III	
24A. BURIAL, CREMATION, REMOVAL (Specify) 10-6-66		24B. DATE 10-6-66		24C. NAME OF CEMETERY OR CREMATORY The Johns Hopkins Hospital	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 10493	
BIRTH NO. 66 10493		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCOTT S. WILLIAMS	
2. DATE AND HOUR OF DEATH 10-16-66 3:40 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
33 THE JOHNS HOPKINS HOSPITAL		MARYLAND, ANNE ARUNDEL			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	
8. DATE OF BIRTH 3-29-66		9. AGE (In years last birthday) 6		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) Md.		12. STREET ADDRESS (If rural, give location) 39 CEDAR RD.		13. FATHER'S NAME BRUCE WILLIAMS	
14. MOTHER'S MAIDEN NAME PHYLLIS HARTING		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT BRUCE WILLIAMS		ADDRESS ABOVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) WILMS TUMOR WITH METASTASES		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 7/29/1966 to 10/16/1966, that (2) (we) last saw the deceased alive on 10/16/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE David C. Mauger		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/16/66	
23C. PHYSICIAN'S NAME (Type) DAVID C. MAUGER		23D. ADDRESS JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 10-19-66		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Robert E. Farber	
25D. ADDRESS		25E. ADDRESS			

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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		Baltimore City Health Department		Registered No.	
66 10494		66 10494		66 10494	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Ronald Lee Bryson		10/17/66 8:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
		Md.		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
University Hospital		Glen Burnie, Md.		52-20	
38 Green Street; Balt. 1, Md.		141 S. Meadow Dr.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W	Single	3/12/46	20	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
none		none		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)	
Garland Bryson Sr.		Sybil Lundy		-	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
-		Garland Bryson Sr.		SAME AS #4	
18. 204.3 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		Acute Lymphatic Leukemia - (18 months)	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO		Gram Neg. Sepsis (agent unknown)	
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		since onset		19 to Oct. 17 1966	
that (I) (we) last saw the deceased alive on		Oct. 17		1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Rouhen Tyji				Oct. 17, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Rouhen Tyji		University Hospital, Dept. of Hematology			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10/20/66		Lakeview Cemetery	
				Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 19 1966		Robert E. Taylor		Robert P. Paine	
				Address	
				Singleton Funeral Home / Glen Burnie, Md.	

University Hospital  
Green Street, Bath, 1, W.

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Gordon Rogers 24

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141 2 Meadow Dr.  
141 2 Meadow Dr.

3/12/44 20  
Mansfield  
Safely Landed

Green Hill (right unknown)  
Acute lymphatic leukemia - (141)  
England 1944-45

Oct 17 1944

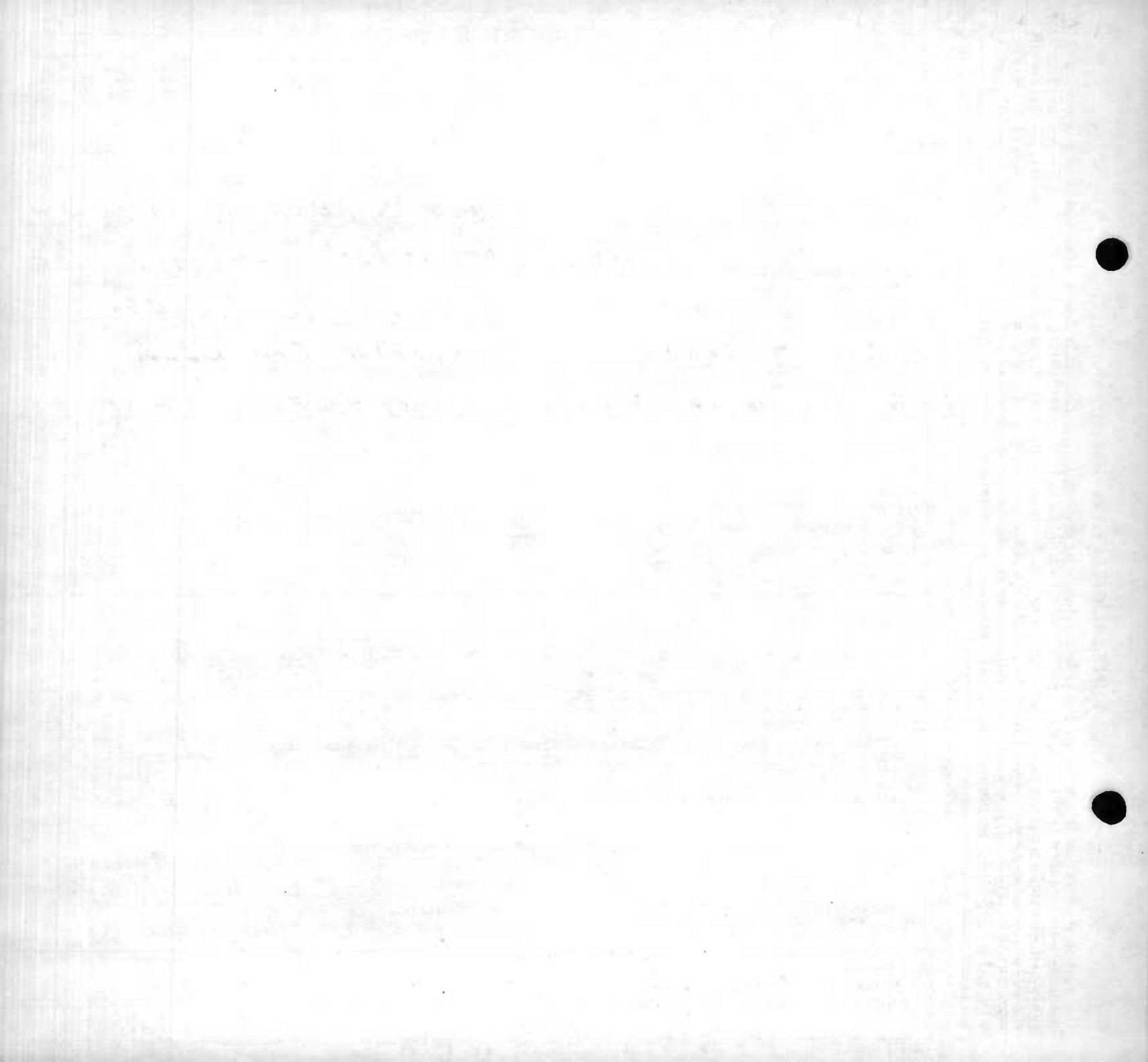
University Hospital, Dept of Medicine  
Green Hill, Bath, 1, W.



# FUNERAL DIRECTOR: IMPORTANT

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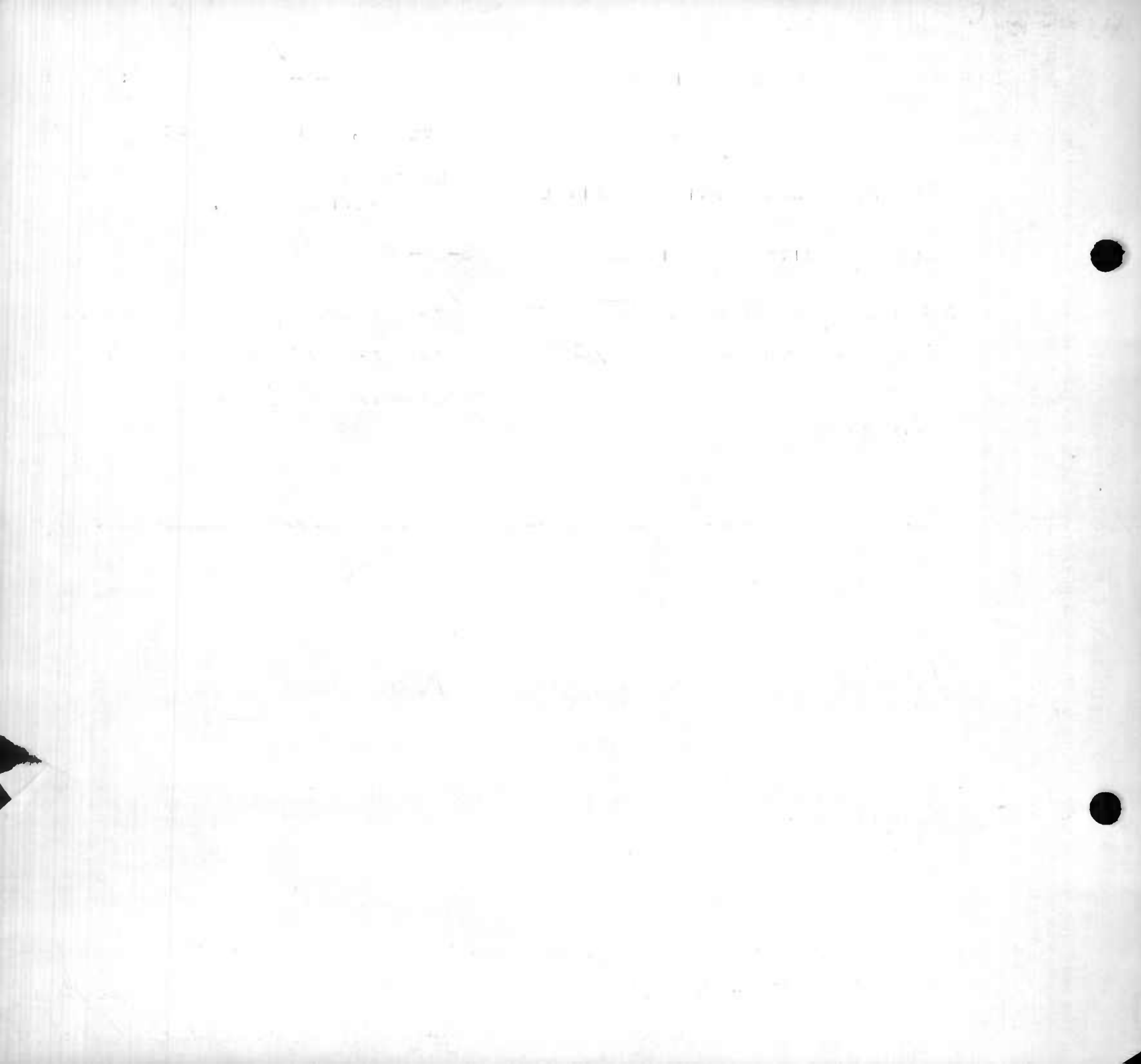
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 10495</u>	
BIRTH NO. <u>66 10495</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>JACOB THACKER</u>		2. DATE AND HOUR OF DEATH <u>10/14/66</u> <u>5:40 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u> D. STREET ADDRESS (If rural, give location) <u>326 S. NEWKIRK ST</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT 14 1910</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL</u>	11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>FRANCIS THACKER</u>			14. MOTHER'S MAIDEN NAME <u>ROBERTA CAPLINGER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES MAR 1944 - APR 1946</u>		16. SOCIAL SECURITY NO. <u>218-05-6355</u>	17. INFORMANT <u>MATILDA THACKER</u> ADDRESS <u>326 S. NEWKIRK</u>		
18. <u>42211 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Acute Pneumonia RLL</u> DUE TO (B) <u>Chronic Heart Failure</u> DUE TO (C) <u>ASCUR</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>8 mon</u> <u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/5/66</u> 19 to <u>10/14/66</u> 19, that (I) (we) lost saw the deceased alive on <u>10/14/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/15/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>COST</u>		23D. ADDRESS <u>MERCY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>10/18/66</u>	24C. NAME of CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 19 1966</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>300 Mon</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

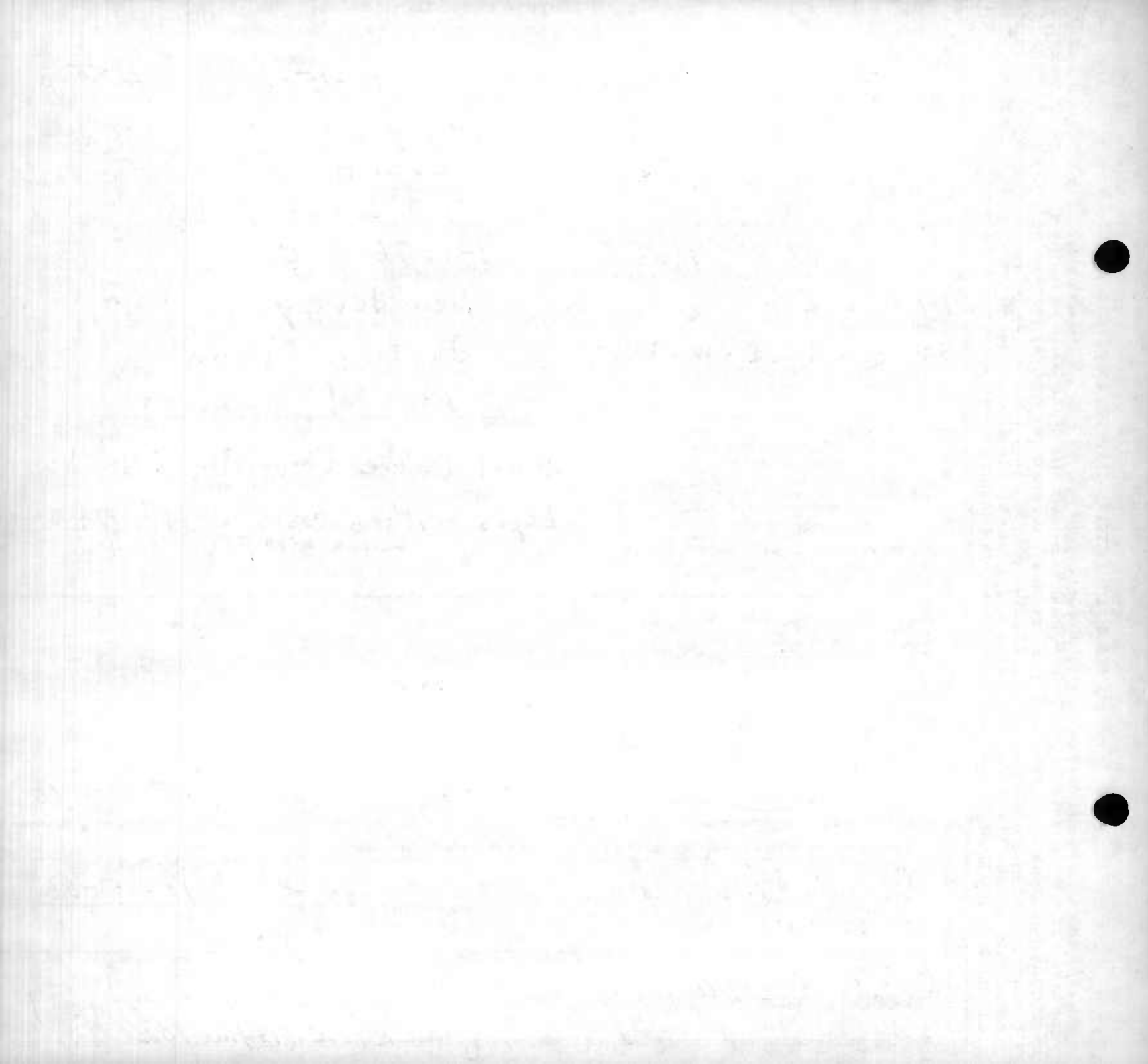
BIRTH NO. 66 10496		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 10496	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GERHARD WINGE			2. DATE AND HOUR OF DEATH 10-2-66 6:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MARYLAND, PRINCE GEORGE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) COLLEGE PARK 66-00 D. STREET ADDRESS (If rural, give location) 10240 BALTIMORE AVE.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 6-22-08	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) captain of waiters restaurant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME August Karl Winge		14. MOTHER'S MAIDEN NAME Gertrud Schmatta	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO.		17. INFORMANT Horstmar Bogell ADDRESS	
18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Metabolic deterioration DUE TO (B) Hepato-renal failure DUE TO (C) Post-necrotic Cirrhosis		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days ?- months → years
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 9-24-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Portal Hypertension		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7-13 1966 to 10-2 1966 that (1) (we) last saw the deceased alive on 10-2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE H.C. Parks M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-2-66	
23C. PHYSICIAN'S NAME (Type) H.C. Parks				23D. ADDRESS M.D. Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 10-14-66		24C. NAME OF CEMETERY or CREMATORY Ft. Lincoln Crematory Calmar Maryland Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. OCT 19 1966			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Donald E. Connelley		ADDRESS Rural Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 10497</b>	
BIRTH NO. <b>66 10497</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Florence Mazur</b>		2. DATE AND HOUR OF DEATH <b>10-15-66 4:55 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2, 2, Co</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Severn 52-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>77 Lucky Rd.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-8-26</b>	9. AGE (In years last birthday) <b>40</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Stephen Demeter</b>		14. MOTHER'S MAIDEN NAME <b>Justine DiKun</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Medical Records</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>705741</b>		CAUSE OF DEATH (A) <b>Renal Failure (Nephrotic syndrome)</b> DUE TO (B) <b>Lupus erythematosus &amp; Lupus nephritis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 Months 1 1/2 years.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <b>9-24</b> 19 <b>66</b> to <b>10-15</b> 19 <b>66</b> , that (II) <u>we</u> last saw the deceased alive on <b>10-15</b> 19 <b>66</b> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard D. Shuger</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-15-66</b>	
23C. PHYSICIAN'S NAME (Typed) <b>David Shuger</b>		M.D. 23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct 19/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Gertrude's Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodbridge New Jersey</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1966</b>		25B. NAME OF REGISTRAR <b>Robert F. Farkner</b>	
25C. FUNERAL DIRECTOR <b>William L. Linnell</b>		ADDRESS <b>Home Bldg</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 10498		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 10498	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NAOMI BLADES T.		2. DATE AND HOUR OF DEATH 10/17/66 505 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 25, MD 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL 38		D. STREET ADDRESS (If rural, give location) 19 WALLACE AVE.			
5. SEX F	6. RACE Cacc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 11/13/99	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME FRANK BEDSWORTH		14. MOTHER'S MAIDEN NAME ISABELLA WESTER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ROLAND BLADES 19 WALLACE AVE	
18. 430.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 HRS	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) Atherosclerotic coronary artery disease DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct. 17 1966 to Oct. 17 1966, that (1) (we) last saw the deceased alive on Oct. 17 1966 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (and) (did not) view the body after death.					
23A. SIGNATURE Dr. O. P. Poteril		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/17/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/20/66		24C. NAME OF CEMETERY or CREMATORY CEDAR HILL	
24D. LOCATION (City, town, or county) Baltimore, Md		24E. STATE (State) Md			
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1966		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS McCully F.H. 237 Patapsco Ave.	



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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 10500				BALTIMORE CITY HEALTH DEPT.		Registered No. 66 10500	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Nicholas Taylor</b>				2. DATE AND HOUR OF DEATH <b>October 17, 1966 10: 55a M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>1116 Stoddard Court</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Dec. 28, 1881</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gen Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GILBERT Taylor</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-07-2805A</b>		17. INFORMANT <b>Stafford G. Taylor-son</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pericely</b>				CAUSE OF DEATH <b>Pericely</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Protruso pneumonia</b>				(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>October 6, 1966</b> to <b>October 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>October 17, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Laredo</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>October 18, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. Laredo</b>				23D. ADDRESS <b>1514 Division Street-Baltimore 17, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/21/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. PK</b>		24D. LOCATION (City, town, or county) (State) <b>Maryland MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Memorial Park 638 N. Green St</b>		ADDRESS	

October

1514 Madison Street  
Baltimore, Maryland

Life Standard Court

84

Dec. 28, 1881

Dear

Friend

My dear

Friend

Enclosed are Baltimore, Maryland

My dear

Friend

My dear

Friend

Yes

October 15

October 15

October 15

October 15

My dear

My dear